89 37382

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William W. Broder
2. DATE OF DEATH: MONTH 12 DAY 26 YEAR 89
3. TIME OF DEATH: 5:30 A M
4. SOCIAL SECURITY NUMBER: 217-22-6463
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/12/1900
8. BIRTHPLACE (State or Foreign Country): Russia
9a. FACILITY NAME (If not institution, give street and number): Fernwood House BETHESDA, MD
9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA MD
9c. COUNTY OF DEATH: MONT.

RESIDENCE OF DECEDENT

10a. STATE: FLORIDA
10b. COUNTY: DADE
10c. CITY, TOWN OR LOCATION: MIAMI
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 11030 SOUTH-WEST 125th ST.
10f. ZIP CODE: 33176
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUSINESS OWNER
16b. KIND OF BUSINESS/INDUSTRY: LIQUOR STORE
17. FATHER'S NAME (First, Middle, Last): SAMUEL BRODER
18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNIE (UNK)
19a. INFORMANT'S NAME (Type/Print): JEROME BRODER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8600 Ewing Dr: BETHESDA, MD 20817
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): KING DAVID MEM. GARDEN
20c. LOCATION — City or Town, State: FALLS CHURCH, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leander U Stone
22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE MD 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CORONARY ARTERY DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE, SECOND DEGREE A-V BLOCK, AMAUROSIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: I. Mizus, MD
29c. LICENSE NUMBER: D26571
29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IRVING MIZUS, MD 5413 W. CEDAR LANE BETHESDA, MD 20814
31. DATE FILED (Month, Day, Year): 1/3/90
32. REGISTRAR'S SIGNATURE: Jane Davidson-Broder

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 26's marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3+3

89 37383

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MYRTLE Myrtle J. Boyer BOYER					2. DATE OF DEATH Month: Dec. 31 Day: 1989 Year	3. TIME OF DEATH 10:10AM M	
4. SOCIAL SECURITY NUMBER: 217-16-2074	5. SEX: 1 ☐ M 2 ☒ F FEMALE	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/11/02	8. BIRTHPLACE (State or Foreign Country): MARYLAND	
9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK		9c. COUNTY OF DEATH: FREDERICK		
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY: CARROLL		10c. CITY, TOWN OR LOCATION: KEYMAR		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO		
10e. STREET AND NUMBER: 906 CROUSE MILL RD.			10f. ZIP CODE: 21757		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed W ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: NO		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 / College (1-4 or 8+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER		16b. KIND OF BUSINESS/INDUSTRY: FACTORY		
17. FATHER'S NAME (First, Middle, Last): ROBERT EYLER			18. MOTHER'S NAME (First, Middle, Maiden Surname): NETTIE GESSINGER				
19a. INFORMANT'S NAME (Type/Print): HARRY J. BOYER			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 906 CROUSE MILL RD. KEYMAR MD 21757				
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify) BURIAL			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. HOPE CEMETERY		20c. LOCATION — City or Town, State: WOODSBORO, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Catharine O. Hartzler			22. NAME AND ADDRESS OF FACILITY: D. D. HARTZLER & SONS WOODSBORO, MD				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Urinary Tract Infection with Sepsis	3 Days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATN? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert L. Kaufmann, MD	D-13971	▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT L. KAUFMANN 300 W. 9TH ST. FREDERICK, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 4 '90	Julia Dillon-Randall

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37384

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM MARTIN BOWLES, SR.			2. DATE OF DEATH (Month, Day, Year): DECEMBER 26, 1989	3. TIME OF DEATH: 18:15 P M
4. SOCIAL SECURITY NUMBER: 215-36-3755	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-31-38	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): ST., MARY'S HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: LEONARDTOWN, MD.		9c. COUNTY OF DEATH: ST. MARY's

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: ST. MARY'S	10c. CITY, TOWN OR LOCATION: MECHANICSVILLE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. BOX 921		10f. ZIP CODE: 20659	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8TH GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC	16b. KIND OF BUSINESS/INDUSTRY: AUTO	
17. FATHER'S NAME (First, Middle, Last): LEWIS C. BOWLES, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH AGNES QUADE	
19a. INFORMANT'S NAME (Type/Print): CAROLE ANN BOWLES		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 526 BEDFORD ST., CUMBERLAND, MD. 21502	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EVERGREEN MEMORIAL	20c. LOCATION — City or Town, State: GREAT MILLS, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael L. Gardiner		22. NAME AND ADDRESS OF FACILITY: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Sudden Death	Minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Prob Cardiac Arrhythmia	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Asst. Dep. Med Examiner	29c. LICENSE NUMBER: D25730	29d. DATE SIGNED (Month, Day, Year): 12/29/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): David Allen MD Box 60 Leonardtown Md 20650			
31. DATE FILED (Month, Day, Year): JAN 01 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(6)

89 37385

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)			3. TIME OF DEATH
MARY	DOROTHY	BARBER	12	29	89	5:42 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-52-8868	1 ☐ M 2 ☒ F	69 YRS.			MARCH 21, 1920	MARYLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Prince George's General Hospital	Cheverly	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	ST. MARY'S	MECHANICSVILLE	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
RT. #1, BOX 51	20659	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 6+)		
12		BUTCHER	FOOD SERVICE

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN HENRY CHASE	MARY RITA SPEARS

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
DOROTHY THOMPSON	BOX R, CALIFORNIA, MARYLAND 20619

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	CHARLES MEMORIAL	LEONARDTOWN, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Edward W. Brinsfield	BRINSFIELD FUNERAL HOME P.O. BOX 279, LEONARDTOWN, MD. 20650

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	12-29-89	4:20p M	1 ☐ YES 2 ☒ NO	Passenger of auto/autos impact
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): St. Mary's Co.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita A. Korell	OCME	▶ 12-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D.-Assistant 111 Penn Street Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 01 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37386

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELEN C. BAILEY			2. DATE OF DEATH (Month, Day, Year): 12 18 89	3. TIME OF DEATH: 4:40 M
4. SOCIAL SECURITY NUMBER: 213-03-4682	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-9-1896	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): MALLARD BAYNURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: CAMBRIDGE	9c. COUNTY OF DEATH: DORCHESTER COUNTY	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: DORCHESTER	10c. CITY, TOWN OR LOCATION: CAMBRIDGE	10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO	
10e. STREET AND NUMBER: TRAVERS STREET		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY: –		
17. FATHER'S NAME (First, Middle, Last): FRANK NENGEL		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY MUTH		
19a. INFORMANT'S NAME (Type/Print): HELEN ABEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3511 GREEN POINT ROAD, EAST NEW MARKET, MARYLAND		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MOST HOLY REDEEMER CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leonard D. Zeller		22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME EAST NEW MARKET, MD 21631		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHF

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. (C Mastectomy for Ca.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: attending MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ 12/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): JAN 4 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JULIA R. BUSSELL			2. DATE OF DEATH (Month, Day, Year): 12 22 89	3. TIME OF DEATH: 4 PM M
4. SOCIAL SECURITY NUMBER: 578-32-7176	5. SEX: 1 ☐ M 2 ☒ F	8. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09 10 22	6. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGES
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: District Heights		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6703 Halleck Street		10f. ZIP CODE: 20747		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Relmon Warren		18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Mae Jordan		
19a. INFORMANT'S NAME (Type/Print): Richard H. Bussell Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6703 Halleck St., District Heights, MD. 20747		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery		20c. LOCATION — City or Town, State: Suitland, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dyna A Welbourn		22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumoniae	8 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Angioimmunoblastic lymphadenopathy with Dysproteinemia	5 mos
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kai-Yin Yeung M.D.	D14730	▶ 12-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Kai-Yin YEUNG, M.D. 8926 Woodyard Rd #201 Clinton, MD 20735

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 04 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

(8)

89 37388

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Nina Gotcher Bender			2. DATE OF DEATH Month: 12 Day: 25 Year: 89	3. TIME OF DEATH: 0242 M
4. SOCIAL SECURITY NUMBER: 312 01 5785	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 01/01	8. BIRTHPLACE (State or Foreign Country): Sanger Tx.
9a. FACILITY NAME (If not institution, give street and number): AAMC Anne Arundel Gen. Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: ANNapolis	9c. COUNTY OF DEATH: ANNe Arundel	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Edgewater	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 11 Wilelinor Drive		10f. ZIP CODE: 21037	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ---------- College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: Public School		
17. FATHER'S NAME (First, Middle, Last): Samuel Gotcher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Willie E. Sullivan		
19a. INFORMANT'S NAME (Type/Print): Charles Bender		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 Wilelinor Drive Edgewater Maryland 21037		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E Evans Pres		22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	SUDDEN DEATH (CARDIORESPIRATORY ARREST) OF	5 MIN
DUE TO (OR AS A CONSEQUENCE OF):	UNCLEAR CAUSE	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):		
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: DEMENTIA SECONDARY TO NORMAL PRESSURE HYDROCEPHALUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert Scott Eden MD.	D30701	▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT SCOTT EDEN, M.D., 703 GIDDINGS AVE., ANNAPOLIS, MD 21401

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 09 '90	Judith Davidson Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37389

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6, if returned by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Douglas Woodall Bozman			2. DATE OF DEATH: MONTH 12 DAY 27 YEAR 89	3. TIME OF DEATH: 9:50P M
4. SOCIAL SECURITY NUMBER: 214-80-1447	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 27 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12/22/1962	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Princess Anne	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Stewart Neck Rd.		10f. ZIP CODE: 21853	10g. CITIZEN OF WHAT COUNTRY?: U.S.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Excavating Work	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): William Bozman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Dolly Catlin	
19a. INFORMANT'S NAME (Type/Print): William Bozman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Upper Fairmount, Md. 21867	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beechwood Cemetery	20c. LOCATION — City or Town, State: Princess Anne, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Hinman Funeral Home, 127 Somerset Ave., Princess Anne, Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-27-89	28b. TIME OF INJURY: 8:00PM	28c. INJURY AT WORK? 1 ☒ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED: Driver of dump truck/struck fixed object
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 13, N. at Revel's Neck Road

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶12-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant		111 Penn St., Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): DEC 28 89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37390

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EUGENE V. BOSWORTH
2. DATE OF DEATH (Month, Day, Year): 12-23-89
3. TIME OF DEATH: 6:30 P M
4. SOCIAL SECURITY NUMBER: 578-16-8514
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 69 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 02/21/20
8. BIRTHPLACE (State or Foreign Country): Washington, Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hosp
9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale Md
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: Hyattsville
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3205 Madison Street
10f. ZIP CODE: 20782
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: 11/22/43 - 02/21/80
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sheet Metal Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Heat & Air Conditioning
17. FATHER'S NAME (First, Middle, Last): Robert Bosworth
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Griggs
19a. INFORMANT'S NAME (Type/Print): Hennie S. Bosworth (Wife)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3205 Madison Street Hyattsville, Maryland 20782
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular fibrillation

DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c. Stroke

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.
29c. LICENSE NUMBER: D19891
29d. DATE SIGNED (Month, Day, Year): 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4404 Queens Way Rd Riverdale MD 20737

31. DATE FILED (Month, Day, Year): DEC 29 '89
32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

(10) (WA)

89 37391

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gertrude H. Bozman				2. DATE OF DEATH: MONTH 12 DAY 27 YEAR 89	3. TIME OF DEATH: 9:55 P M	
4. SOCIAL SECURITY NUMBER: 218-05-6250	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3-8-1906	8. BIRTHPLACE (State or Foreign Country): Maryland	
9a. FACILITY NAME (If not institution, give street and number): Salisbury Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury, Md.		9c. COUNTY OF DEATH: WICOMICO	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Somerset		10c. CITY, TOWN OR LOCATION: Princess Anne		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: Route 3.			10f. ZIP CODE: 21853		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary		16b. KIND OF BUSINESS/INDUSTRY: Health Services	
17. FATHER'S NAME (First, Middle, Last): John A. Holland			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Cluff			
19a. INFORMANT'S NAME (Type/Print): Leland H. Bozman			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1009 Russell Avenue, Salisbury, Md. 21801			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Beechwood Cemetery		20c. LOCATION — City or Town, State: Pr. Anne, Md. 21853	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] M00295			22. NAME AND ADDRESS OF FACILITY: Hinman Funeral Home Princess Anne, Md. 21853			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple CVA's DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Generalized arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):	
	c. ~~Cardiac~~ Peptic ulcer disease DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D29349	▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM ROBINS, M.D., RT. 50 & CIVIC AVE., SALISBURY, MD. 21801

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37392

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2/3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELSWORTH . BROOKS					2. DATE OF DEATH (Month / Day / Year): 12 / 31 / 89	3. TIME OF DEATH: 4.58 PM M
4. SOCIAL SECURITY NUMBER: 578-14-7853	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-31-1900	8. BIRTHPLACE (State or Foreign Country): Washington D.C.
9a. FACILITY NAME (If not institution, give street and number): NORTH ARUNDEL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: GLEN BURNIE		9c. COUNTY OF DEATH: A.A. COUNTY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGES	10c. CITY, TOWN OR LOCATION: RIVERDALE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: [illegible] 50th AVE. RIVERDALE Md.		10f. ZIP CODE: 20772	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Blk.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY: Trucking	
17. FATHER'S NAME (First, Middle, Last): John Brooks		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Bowman	
19a. INFORMANT'S NAME (Type/Print): Anna M. Bryant	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2511 Brown Station Rd. Upper Marlboro, M.d.		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HARMONY MEMORIAL PARK	20c. LOCATION — City or Town, State: Landover, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Phillip Bell	22. NAME AND ADDRESS OF FACILITY: Capitol Mortuary 1425 Maryland Ave., N.E. Wash.D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Metastatic cancer of the Colon.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Aspiration.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward Sherman M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 12-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
EDWARD N. SHERMAN, M.D. 95 AQUAHART ROAD, #203 GLEN BURNIE, MARYLAND 21061

31. DATE FILED (Month, Day, Year): JAN 09 '90	32. REGISTRAR'S SIGNATURE: [illegible]

DHMH-16 Rev 1/89

89 37393

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 ... use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): SEAN JOSHUA CROSBY				2. DATE OF DEATH (Month, Day, Year): 12 31 89	3. TIME OF DEATH: 425 PM
4. SOCIAL SECURITY NUMBER: 578-98-5827	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 23 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/3/66	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): 4813 TALLAHASSEE DRIVE			9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4813 Tallahassee Avenue		10f. ZIP CODE: 20853	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Firefighter/EMT	16b. KIND OF BUSINESS/INDUSTRY: Emergency Response

17. FATHER'S NAME (First, Middle, Last): Wayne Joshua Crosby	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Myrtle Orndorff
19a. INFORMANT'S NAME (Type/Print): Kenneth Hamilton Crosby	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9202 Adelaide Court Bethesda, Maryland 20817

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.	20c. LOCATION — City or Town, State: Bethesda, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert A. Farrah M00198	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, MD 20814	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUNSHOT Wound to HEAD	MINUTES
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DEPRESSION	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Paul A DeVore Deputy Medical Examiner	D01852	▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL A DEVORE, MD 4303 Owensboro Rd Hyattsville MD 20781

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

89 37394

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET PEARL COX			2. DATE OF DEATH (Month / Day / Year): 12 / 30 / 89	3. TIME OF DEATH: 8:40 A M
4. SOCIAL SECURITY NUMBER: 218164889	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4-5-24	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: CUMBERLAND		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: ROUTE 5, CRADDOCK ROAD		10f. ZIP CODE: 21502		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY: HOME
17. FATHER'S NAME (First, Middle, Last): CHARLES SAGER		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH KIDWELL		
19a. INFORMANT'S NAME (Type/Print): CAROL J. COX		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ROUTE 5, CRADDOCK ROAD, CUMBERLAND, MD 21502		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HILLCREST BURIAL PARK		20c. LOCATION — City or Town, State: CUMBERLAND, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Theresa M. Yochum		22. NAME AND ADDRESS OF FACILITY: GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Renal failure — Approximate Interval: 1 week

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. metastatic disease

DUE TO (OR AS A CONSEQUENCE OF):

c. Transitional cell carcinoma

DUE TO (OR AS A CONSEQUENCE OF):

d. of Urinary bladder 1983

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Intestinal Obstruction surgery

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
R Espina MD	030459	▶ 1/2/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR, RENATO ESPINA 907 SETON DRIVE CUMBERLAND MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 1990	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please complete by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner is notified at once.

6

89 37395

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 must be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary KATHERINE Cross			2. DATE OF DEATH: MONTH 12 DAY 25 YEAR 89	3. TIME OF DEATH: 3:00 P M
4. SOCIAL SECURITY NUMBER: 215-12-2773	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08-07-18	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Deaton Hospital and Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: ST. MARY'S	10c. CITY, TOWN OR LOCATION: LEONARDTOWN		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: NEWTOWNE VILLAGE		10f. ZIP CODE: 20650		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12TH GRADE; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MEDICAL SECRETARY		16b. KIND OF BUSINESS/INDUSTRY: DOCTOR's OFFICE
17. FATHER'S NAME (First, Middle, Last): HARRY B. CROSS			18. MOTHER'S NAME (First, Middle, Maiden Surname): LILLIAN CAMPBELL	
19a. INFORMANT'S NAME (Type/Print): ROBERT E. CROSS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX 119-A, AVENUE, MD. 20609		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LEE CREMETORY		20c. LOCATION — City or Town, State: CLINTON, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Gardiner		22. NAME AND ADDRESS OF FACILITY: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270 LEONARDTOWN, MD. 20650		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Obstructive Lung Disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H.L. Mudd Jr Med Dir	29c. LICENSE NUMBER: D014622	29d. DATE SIGNED (Month, Day, Year) ▶ 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H.L. Mudd, 601 S. Charles St, Balto, Md		
31. DATE FILED (Month, Day, Year): JAN 05 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37396

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): John A. Coffman			2. DATE OF DEATN (Month, Day, Year): December 24, 1989	3. TIME OF DEATH: 6:50 A M
4. SOCIAL SECURITY NUMBER: 578 54 4038.	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTN (Month, Day, Year): July 18, 1904	8. BIRTNPLACE (State or Foreign Country): Virginia
8a. FACILITY NAME (If not institution, give street and number): Grosvenor Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATN: Bethesda		9c. COUNTY OF DEATN: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2 Whetstone Drive		10f. ZIP CODE: 20877	10g. CITIZEN OF WNAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Hospital Aide	16b. KIND OF BUSINESS/INDUSTRY: Hospital	
17. FATHER'S NAME (First, Middle, Last): Henry Coffman		18. MOTNER'S NAME (First, Middle, Maiden Surname): Frances Not Available	
19a. INFORMANT'S NAME (Type/Print): Mary Madeline Reinhold		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13209 Carriage Court Rockville, Maryland 20850	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE DF DISPOSITION (Name of cemetery, crematory or other place): Washington National Cemetery	20c. LOCATION — City or Town, State: Suitland, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00689		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bronchopneumonia, Bilateral	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATN? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE NOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PNYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D 08546	29d. DATE SIGNED (Month, Day, Year): ▶ December 24,1989

30. NAME AND ADDRESS OF PERSON WNO COMPLETEO CAUSE OF DEATN (ITEM 27) (Type, Print): John F. Tauber, M.D. 8218 Wisconsin Avenue, Bethesda, Maryland 20814

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

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89 3736

89 37397

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Faith Ann Canterbury			2. DATE OF DEATH (Month, Day, Year): 12-23-89	3. TIME OF DEATH: 7:57AM M
4. SOCIAL SECURITY NUMBER: 579-94-9700	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 22 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 19, 1967	8. BIRTHPLACE (State or Foreign Country): Cheverly, Md.
9a. FACILITY NAME (If not institution, give street and number): Prince Georges General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: Prince Georges Co.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: 4309 Oglethorpe Street, Hyattsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4309 Oglethorpe Street		10f. ZIP CODE: 20781	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade	College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): L.S.M. Machine Operator	16b. KIND OF BUSINESS/INDUSTRY: U.S. Postal Service

17. FATHER'S NAME (First, Middle, Last): Michael D. Canterbury	18. MOTHER'S NAME (First, Middle, Maiden Surname): Donna Payne
19a. INFORMANT'S NAME (Type/Print): Michael D. Canterbury (Father)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4309 Oglethorpe Street, Hyattsville, Md. 20781

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha daeth. Do not enter the mode of dying, auch as cardiac or respiratory arrest, shock, or haert feilure. List only one ceuse on aach line.

Approximate Interval Betwsen Onset and Dsath

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Multiple injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, lasding to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 XX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XXX Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 XXX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-23-89	28b. TIME OF INJURY: 6:00A M	28c. INJURY AT WORK? 1 ☐ YES 2 XXX NO	28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/auto impact
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 704/Rt. 70, Landover, Prince Georges County, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr MD	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr.,MD 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-1a Rev 1/89

(10)

89 37398

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN A. COUGHLIN		2. DATE OF DEATH (Month, Day, Year): December 20, 1989	3. TIME OF DEATH: 9:00 p. M
4. SOCIAL SECURITY NUMBER: 326-03-0478	5. SEX: 1 ☐ M 2 XX F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec 2, 1911
8. BIRTHPLACE (State or Foreign Country): Illinois			
9a. FACILITY NAME (If not institution, give street and number): Bethesda Retirement & Nursing Center	9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Chevy Chase	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 8700 Jones Mill Rd.		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Emil F. Bredlow		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna B. Gertenrich	
19a. INFORMANT'S NAME (Type/Print): Wanda Sumner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1 Box 71E, Lovettsville, VA 22080	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory	20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Keith L. Wallace		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons 5130 Wisconsin Av., Washington, DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebral Vascular Accident Mid-Brain	2 Days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Diabetes Mellitus Type II	1970
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Uremia	2 Years
DUE TO (OR AS A CONSEQUENCE OF):		
d.	Hypertensive Cardiovascular Disease	15 Years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Francis J. Murray M.D.	29c. LICENSE NUMBER: DC 935	29d. DATE SIGNED (Month, Day, Year): ▶ December 21,1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Francis J. Murray, M.D., 3301 New Mexico Av. NW, Washington, DC

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

3d

VOIDED DEATH

#89-37399

See Fetals

Baby Boy Clark -12-18-89

Mont Co.

89 37400

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Brian P. Connaughton		December 19, 1989	7:00 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
213-17-1248	1 [X] M 2 [ ] F	2 YRS.			Aug. 13, 1987	Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Shady Grove Adventist Hospital	Rockville	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Germantown	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
12170 Island View Circle	20874	United States

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
0		None	None

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Patrick Connaughton	Mary McClurken

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patrick Connaughton	12170 Island View Circle, Germantown, MD 20874

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Fairfax Memorial Park	Fairfax, Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ T Aaron Tyer M00853	Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, MD 20850

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GRAND MAL SEIZURE	ACUTE
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ECEPHALOPATHY	2 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	12 19 89	4 M	1 [ ] YES 2 [X] NO	FOUND IN BED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
	HOME			SEE #10

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D07099	▶ 12/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FRANCIS C MAYLE 8200 WISCONSIN AVE BETHESDA MD 20814

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

2

89 37401

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hui Mei Lin Chang			2. DATE OF DEATH (Month / Day / Year): 12 / 12 / 89	3. TIME OF DEATH: 12:32 PM
4. SOCIAL SECURITY NUMBER: 215-98-3368	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 47 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 3, 1942	8. BIRTHPLACE (State or Foreign Country): Taiwan
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2878 Glenora Lane		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?: Taiwan

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse	16b. KIND OF BUSINESS/INDUSTRY: Hospital	
17. FATHER'S NAME (First, Middle, Last): Ta Lie Chen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Huang Lin	
19a. INFORMANT'S NAME (Type/Print): Long Hsiung Chang	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2878 Glenora Lane, Rockville, Maryland 20850		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	20c. LOCATION — City or Town, State: Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: M00381 ▶ Barbara Jo McMullen Lawrence	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave.,Bethesda,MD 20814-3501		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pulmonary embolism — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Deep vein thrombosis of lower extremities — DUE TO (OR AS A CONSEQUENCE OF):	
	c. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Arteriosclerotic cardiovascular disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-13-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant 111 Penn Street Baltimore, MD 21201

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37402

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

14

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emily C. Cimochowski

2. DATE OF DEATH (Month, Day, Year): December 21, 1989

3. TIME OF DEATH: 6:15 PM

4. SOCIAL SECURITY NUMBER: 227-30-5417

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 63 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): July 31, 1926

9. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Silver Spring

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 13630 Cedar Creek Lane

10f. ZIP CODE: 20904

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 9
College (1-4 or 5+): –

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Clerk

16b. KIND OF BUSINESS/INDUSTRY: Sears Dept. Store

17. FATHER'S NAME (First, Middle, Last): William Earl Sanderlin

18. MOTHER'S NAME (First, Middle, Maiden Surname): Hanna Murphy

19a. INFORMANT'S NAME (Type/Print): William E. Sanderlin, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7833 Lake Shore Drive, Richmond, Virginia 23235

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Calvary Cemetery

20c. LOCATION — City or Town, State: Richmond, Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michele P. Fritts M00348

22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD. 20814

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Respiratory Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Adenocarcinoma of the Lung

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Herbert S.B. Baraf

29c. LICENSE NUMBER: D21924

29d. DATE SIGNED (Month, Day, Year): ▶ 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Herbert S.B. Baraf, M.D. 10313 Georgia Ave.,#107, Silver Spring,MD 20902

31. DATE FILED (Month, Day, Year): DEC 27 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 37403

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN OTIS CRISLER			2. DATE OF DEATH (Month, Day, Year): DEC. 30, 1989	3. TIME OF DEATH: 10:16 PM
4. SOCIAL SECURITY NUMBER: 257-44-6029	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 5, 1931	8. BIRTHPLACE (State or Foreign Country): GA.
9a. FACILITY NAME (If not institution, give street and number): NAVAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: PATUXENT RIVER	9c. COUNTY OF DEATH: ST. MARY'S	
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: ST. MARY'S	10c. CITY, TOWN OR LOCATION: GREAT MILLS	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 608 BOATNER DR.		10f. ZIP CODE: 20634	10g. CITIZEN OF WHAT COUNTRY?: u.s.a.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Jet Engine Tech.	16b. KIND OF BUSINESS/INDUSTRY: U.S. AIR FORCE		
17. FATNER'S NAME (First, Middle, Last): ROBERT GARR CRISLER		18. MOTNER'S NAME (First, Middle, Maiden Surname): THARA CORMELIA RITCHIE		
19a. INFORMANT'S NAME (Type/Print): LILLIAN C. CRISLER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 608 BOATNER DR., GREAT MILLS, MD. 20634			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NASHVILLE NATL. CEMETERY	20c. LOCATION — City or Town, State: MADISON, TENN.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael K. Gardiner	22. NAME AND ADDRESS OF FACILITY: MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O.BOX 270, LEONARDTOWN, MD. 20650			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Probable Pulmonary Embolist	sec.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Probable Recient AK Amputation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Wm D. Boyd MD	D14285	12/31/1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM D. BOyd II M.D., LEONARDTOWN, MD. 20650

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 01 '90	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(25)

89 37404

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) FURMAN CLIFTON. Furman Clifton, JR.				2. DATE OF DEATH MONTH 12 DAY 12 YEAR 89	3. TIME OF DEATH 7:20P M
4. SOCIAL SECURITY NUMBER 217-07-0940	5. SEX 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) JULY 23, 1904	8. BIRTHPLACE (State or Foreign Country) MARYLAND
9a. FACILITY NAME (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE		9c. COUNTY OF DEATH DORCHESTER

RESIDENCE OF DECEDENT

10a. STATE MARYLAND	10b. COUNTY DORCHESTER	10c. CITY, TOWN OR LOCATION EAST NEW MARKET	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER MD ROUTE 14		10f. ZIP CODE 21631	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11 College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FARMER	16b. KIND OF BUSINESS/INDUSTRY DAIRY	
17. FATHER'S NAME (First, Middle, Last) FURMAN B. CLIFTON, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname) EMMA PERCY	
19a. INFORMANT'S NAME (Type/Print) EMILY COLLINS	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. BOX 218, SECRETARY, MD 21664		
20a. METHOD OF DISPOSITION 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) EAST NEW MARKET CEMETERY	20c. LOCATION — City or Town, State EAST NEW MARKET, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leonard D. Zeller	22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME EAST NEW MARKET, MD 21631		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. O.B.S- Organic Brain Syndrome

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) — 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Vinodrai Mehta, M.D. Attending M.D.		29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 12/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Vinodrai Mehta, M.D. 400 Aurora Street Cambridge, MD 21613			
31. DATE FILED (Month, Day, Year) JAN 4 '90	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall		

DHMH-16 Rev 1/89

89 37405

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Spencer Cusic			2. DATE OF DEATH (Month, Day, Year): December 21, 1989	3. TIME OF DEATH: 1611 M
4. SOCIAL SECURITY NUMBER: 578-48-7964	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 50 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Apr. 10, 1939	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick	9c. COUNTY OF DEATH: Calvert	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Dunkirk	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2187 Regent Court		10f. ZIP CODE: 20754	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: 1962 - 1964	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Contractor	16b. KIND OF BUSINESS/INDUSTRY: U.S.Government	
17. FATHER'S NAME (First, Middle, Last): John William Cusic		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Mae Buckler	
19a. INFORMANT'S NAME (Type/Print): Diane Constantino	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11902 Rivershore Dr. Dunkirk, MD. 20754		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD. 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiogenic shock	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute myocardial infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO. Microscopic pending

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 12/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Mark Kushner M.D. Prince Frederick, Maryland		
31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(16)

89 37406

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bu Yun Cho
2. DATE OF DEATH (Month, Day, Year): Dec 30 1989
3. TIME OF DEATH: 1010 a M
4. SOCIAL SECURITY NUMBER: 217-980303
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 59 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Apr 23 1930
8. BIRTHPLACE (State or Foreign Country): Korea
9a. FACILITY NAME (If not institution, give street and number): National Naval Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Anne Arundel
10c. CITY, TOWN OR LOCATION: Gambrills
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 2108 Eden Wood Lane
10f. ZIP CODE: 21054
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Oriental
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Chang Ho Cho
18. MOTHER'S NAME (First, Middle, Maiden Surname): Kum Soo Chun
19a. INFORMANT'S NAME (Type/Print): Suk Yuenger
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2108 Eden Wood Lane, Gambrills, MD 21054
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate Of Heaven Cemetery
20c. LOCATION — City or Town, State: Silver Spring Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Evans Pres
22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastic Adenocarcinoma
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: 177-44-8325 MD, MC, USN 05-005401-L PA
29d. DATE SIGNED (Month, Day, Year): ▶ 01-01-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): JAN 09 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37407

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled ... doc. page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, ...
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the ... must be notified at once.

2

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILA E CHEERS			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH: 4:06 P M
4. SOCIAL SECURITY NUMBER: 213-24-1292	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-24-1897	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dorchester General		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Queen Anne	10c. CITY, TOWN OR LOCATION: Centerville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: Rt. #2		10f. ZIP CODE: 21617	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic Work	16b. KIND OF BUSINESS/INDUSTRY: Mallard Bay

17. FATHER'S NAME (First, Middle, Last): Robert H. Earle	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary W. Earle
19a. INFORMANT'S NAME (Type/Print): Nettie C. Starkey	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. #4 Box 343 Centerville, Md. 21617

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetery	20c. LOCATION — City or Town, State: Burrsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith	22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services PO Box 928 Hurlock, Md 21643	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	3d 3 d
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. S/P CVA S/P CVA	3y 3 y
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dementia, Dehydration
Dementia, Dehydration

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Craig W. Caldwell, M.D.	29c. LICENSE NUMBER: D33622	29d. DATE SIGNED (Month, Day, Year): ▶ 28 Dec 89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D33622		28 Dec. 89	
31. DATE FILED (Month, Day, Year): JAN - 9 '90	32. REGISTRAR'S SIGNATURE		

DHMH-16 Rev 1/89

89 37408

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be removed and kept by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Francoise CAP					2. DATE OF DEATH: MONTH 12 DAY 27 YEAR 89	3. TIME OF DEATH: 1-55 P.M.
4. SOCIAL SECURITY NUMBER: 176-28-5977	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02/24/06	8. BIRTHPLACE (State or Foreign Country): Prusy, Poland
9a. FACILITY NAME (If not institution, give street and number): Leland Hospital 4409 East west Highway					9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale MD 20737	9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Hyattsville				10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 6502 Queens Chapel Road		10f. ZIP CODE: 20782			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): --------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress			16b. KIND OF BUSINESS/INDUSTRY: Clothing	
17. FATHER'S NAME (First, Middle, Last): Gustav Chomont					18. MOTHER'S NAME (First, Middle, Maiden Surname): Maria Dmitriv	
19a. INFORMANT'S NAME (Type/Print): Jeannine Cap (Daughter)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6502 Queens Chapel Road Hyattsville, Md. 20782	
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery			20c. LOCATION — City or Town, State: Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]					22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave Hyattsville, Md. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coma	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. INTRACEREBRAL HEMORRHAGE (Cerebrovascular Accident)	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension by History
Hyperglycemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] | 29c. LICENSE NUMBER: D22549 | 29d. DATE SIGNED (Month, Day, Year): ▶ 12-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G.M. DIN, M.D. 6510 Kenilworth Ave ; Riverdale M.D. 20737

31. DATE FILED (Month, Day, Year): DEC 29 '89 | 32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

(12)

DHMH-16 Rev 1/89

89 37409

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last): Anne M. Costin	2. DATE OF DEATH: MONTH 12 DAY 25 YEAR 89	3. TIME OF DEATH: 21:02 M	
4. SOCIAL SECURITY NUMBER: 214524462	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (If yrs. last birthday): 42 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 06/24/47
8. BIRTHPLACE (State or Foreign Country): Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hosp	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg C	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 438 Girard St Apt 101	10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dispatcher & Office Manager	16b. KIND OF BUSINESS/INDUSTRY: Triple A Poor Richard's	
17. FATHER'S NAME (First, Middle, Last): Ralph T. Barnes	18. MOTHER'S NAME (First, Middle, Maiden Surname): Opal Marie Harris		
19a. INFORMANT'S NAME (Type/Print): Ralph Barnes (Brother)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 73 E. Ridge Road, Greenbelt, Md. 20770		
20a. METNOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): George Washington Cemetery	20c. LOCATION — City or Town, State: Adelphi, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiogenic shock and congestive heart failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Extensive myocardial infarction, posterior left ventricular	1 week
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Calafic atherosclerosis	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Obesity Diabetes mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Theodore G Kanen	D19736	▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Theodore G. Kanen, M.D. Shady Grove Hospital, Rockville, Maryland

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37410

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances Iden Cranford
2. DATE OF DEATH (Month, Day, Year): December 23, 1989
3. TIME OF DEATH: 1:40 P.M.
4. SOCIAL SECURITY NUMBER: 214-30-1326
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 20, 1910
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Ft. Washington Rehabilitation
9b. CITY, TOWN OR LOCATION OF DEATH: Ft. Washington
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: UPper Marlboro
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Post Office Box 103
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (10) — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Levi Morgan Nalls
18. MOTHER'S NAME (First, Middle, Maiden Surname): Salome ----- Cornwell
19a. INFORMANT'S NAME (Type/Print): Gerald F. Cranford
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4909 Colonel Contee Place, Upper Marlboro, Md. 20772
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery
20c. LOCATION — City or Town, State: Clinton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard A. Coleman
22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home, 14513 Main St., Upper Marlboro, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atherosclerosis of Heart Cardiomyopathy

DUE TO (OR AS A CONSEQUENCE OF):

c. Congestive Heart Failure

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Dr Berwa MD Attending
29c. LICENSE NUMBER: D-24535
29d. DATE SIGNED (Month, Day, Year): 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Laxmi N. Berwa, 1300 Mercantile Lane #134, Landover, Maryland 20785
31. DATE FILED (Month, Day, Year): JAN 09 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37411

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Violet E. Dodson
2. DATE OF DEATH — MONTH: 12 DAY: 23 YEAR: 89
3. TIME OF DEATH: 7 12 PM
4. SOCIAL SECURITY NUMBER: 578-22-2875-A
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Aug. 9, 1908
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Beltsville Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Laurel
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George's
10c. CITY, TOWN OR LOCATION: College Park
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9014 Rhode Island Avenue
10f. ZIP CODE: 20740
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th Grade — College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Lady
16b. KIND OF BUSINESS/INDUSTRY: Heght Company
17. FATHER'S NAME (First, Middle, Last): James Tumblin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eliza McFarling
19a. INFORMANT'S NAME (Type/Print): Kathy Webb (Daughter)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4917 Blackfoot Road, College Park, Maryland 20740
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMATORY
20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Randy R. Brokaw
22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypetension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes / Atherosclerotic cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D25430
29d. DATE SIGNED (Month, Day, Year): 12/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 14333 Laurel Bowie Rd #307 Laurel, MD 20708
31. DATE FILED (Month, Day, Year): DEC 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(5)

89 37412

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached by the funeral or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bernard Grant Davidson			2. DATE OF DEATH (Month, Day, Year): December 29, 1989	3. TIME OF DEATH: 3:06 P M
4. SOCIAL SECURITY NUMBER: 578-18-2427	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 17, 1918	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): 17912 Mill Creek Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Derwood	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Derwood	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 17912 Mill Creek Drive		10f. ZIP CODE: 20855	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 6+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lithographer	16b. KIND OF BUSINESS/INDUSTRY: Dept. of Defense	
17. FATHER'S NAME (First, Middle, Last): Lewis Grant Davidson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Cumberland	
19a. INFORMANT'S NAME (Type/Print): Mazine Coleman Davidson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17912 Mill Creek Dr, Derwood, MD 20855	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory	20c. LOCATION — City or Town, State: Silver Spring, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William B. Clark MOO 827		22. NAME AND ADDRESS OF FACILITY: Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hepatic Coma	1 day
DUE TO (OR AS A CONSEQUENCE OF): b.	Cirrhosis of Liver	1 yr.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Hepatitis, non A, non B	3 yrs
d.	Blood transfusion	3 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary heart disease
Diabetes mellitus

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D01193	29d. DATE SIGNED (Month, Day, Year): December 29, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sidney J. Cohen, M. D., 121 Congressional Lane, Rockville, MD 20852

31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

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89 37413

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IRENE S. DANIELS					2. DATE OF DEATH (Month, Day, Year): DEC. 29, 1989		3. TIME OF DEATH: 3:10 P. M
4. SOCIAL SECURITY NUMBER: 579-10-2146	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): APRIL 5, 1913		8. BIRTHPLACE (State or Foreign Country): WASHINGTON, DC
9a. FACILITY NAME (If not institution, give street and number): 1902 DAYTON STREET			9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING			9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT							
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY		10c. CITY, TOWN OR LOCATION: SILVER SPRING			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: 1902 DAYTON STREET			10f. ZIP CODE: 20902			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. OECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PURCHASING AGENT		16b. KIND OF BUSINESS/INDUSTRY: N.I.H.			
17. FATHER'S NAME (First, Middle, Last): UNKNOWN SELLNER			18. MOTHER'S NAME (First, Middle, Maiden Surname): ELEANOR AGNES OWENS				
19a. INFORMANT'S NAME (Type/Print): JANET D. BRYNER (DAUGHTER)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3615 MELINDA COURT, MONROVIA, MARYLAND 21770				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FORT LINCOLN CEMETERY		20c. LOCATION — City or Town, State: BRENTWOOD, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]			22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cardiovascular collapse
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. cardiac arrhythmias
DUE TO (OR AS A CONSEQUENCE OF):
c. acute myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Joseph M. Solinas MD	D 10101	▶ 12/29/1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOSEPH M. SOLINAS, M.D. 9801 GEORGIA AVENUE, SILVER SPRING, MARYLAND

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be retained for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37414

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gladys Leah Daub					2. DATE OF DEATH (Month, Day, Year): 12- 26- 89	3. TIME OF DEATH: 4:45 p M
4. SOCIAL SECURITY NUMBER: 162-22-5210	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 07-23-26	8. BIRTHPLACE (State or Foreign Country): Palmyra, Pa.
9a. FACILITY NAME (If not institution, give street and number): 979 Pond Neck Rd.			9b. CITY, TOWN OR LOCATION OF DEATH: Earleville		9c. COUNTY OF DEATH: Cecil	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Earleville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 979 Pond Neck Rd.		10f. ZIP CODE: 21919	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): Roy Kerr		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Price	
19a. INFORMANT'S NAME (Type/Print): Donna Hoffer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 979 Pond Neck Rd. Earleville, Md. 21919		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Con-O-lite Cem.	20c. LOCATION — City or Town, State: Schaefferstown, Pa	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary B. Fellows	22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Homes, Box 270 Millington, Md. 21651		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Breast Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Barbara A Lavarone	29c. LICENSE NUMBER: MD D25915	29d. DATE SIGNED (Month, Day, Year): 12-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Cecil-Kent Health Ctr, Cecilton, Md.		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-16 Rev 1/89

89 37415

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
ELEANOR	L	DUNN	12 / 28 / 89	1116 PM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
220-30-0235	1 ☐ M 2 ☒ F	74 YRS.			3-19-15	Wash.D,C,

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
NORTH ARUNDEL HOSPITAL	GLEN BURNIE	A.A. COUNTY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	Anne Arundel	Harmans	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4 Lexington Rd.	21077	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
Unknown		Clerk Typist	Government

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Charles Roe	

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
James Dunn	5405 Broadwater Ln.Clarksville,Md21029

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Balt.-Wash. Crematory	Laurel, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John Lella Slack moo535	Slack Funeral Home POBox 268 Ellicott City,Md.21043

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Left Ventricular failure	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive heart failure	chronic
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Coronary atherosclerosis	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D0 1828	▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
MAX C. FRANK M.D. 7575 RITCHIE HIGHWAY SE GLEN BURNIE, MARYLAND 21061	

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 '90	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37415

89 37416

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Elizabeth Davis
2. DATE OF DEATH (Month / Day / Year): 12 / 28 / 89
3. TIME OF DEATH: 430 A M
4. SOCIAL SECURITY NUMBER: 225-34-2926
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs, last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/24/13
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Sinai Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, MD
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Baltimore
10c. CITY, TOWN OR LOCATION: Randallstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9109 Liberty Road
10f. ZIP CODE: 21133
10g. CITIZEN OF WHAT COUNTRY: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housemaid
16b. KIND OF BUSINESS/INDUSTRY: Private Home
17. FATHER'S NAME (First, Middle, Last): Garfield Watkins
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mabelle Foster
19a. INFORMANT'S NAME (Type/Print): Ferris Funeral Services
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 427 E. Main Street, Abingdon, Va. 24210
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowview Cemetery
20c. LOCATION — City or Town, State: Meadowview, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Home, 5695 Main Street, Elkridge, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis	3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Urinary Tract Infection	1 week.
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dementia, Anemia, Cerebrovascular accident
24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD PhD, Resident Physician
29c. LICENSE NUMBER: 9312
29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Irving Weinberg MD PhD, Dept of Medicine, Sinai Hosp of Baltimore.
31. DATE FILED (Month, Day, Year): JAN 2 '90
32. REGISTRAR'S SIGNATURE: Jacqueline Davidson-Randall

DHMH-16 Rev 1/89

89 37417

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVELYN Evelyn De Ferrari / DEFERRARI
2. DATE OF DEATH: MONTH 12 DAY 21 YEAR 89
3. TIME OF DEATH: 1 40 A M
4. SOCIAL SECURITY NUMBER: 579-44-2813
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan 13, 1897
8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): CARRIAGE HILL NURSING CENTER 9101 SECOND AVE.
9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING,
9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: ---
10b. COUNTY: ---
10c. CITY, TOWN OR LOCATION: Washington, D.C.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3820 Argyle Terr. N.W.
10f. ZIP CODE: 20011
10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 0
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): John Biggi
18. MOTHER'S NAME (First, Middle, Maiden Surname): Christina Gatti
19a. INFORMANT'S NAME (Type/Print): Austin J. DeFerrari
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3820 Argyle Ter. NW, Washington, DC 20011
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery
20c. LOCATION — City or Town, State: Silver Spring, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Keith L. Markus
22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons 5130 Wisconsin Av., Washington, DC 20016

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral Vascular accident
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerosis
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY — M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: JB Umhau MD
29c. LICENSE NUMBER: D11025
29d. DATE SIGNED (Month, Day, Year): ▶ 12/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John B. Umhau, 8805 Conn. Ave. Chevy Chase Md. 20815
31. DATE FILED (Month, Day, Year): 12/21/89 DEC 27 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18

89 37418

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN BERNARD DUNNE			2. DATE OF DEATH (Month, Day, Year): Dec. 31, 1989	3. TIME OF DEATH: 7:00 AM M
4. SOCIAL SECURITY NUMBER: 212-07-2703	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 12, 1904	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 754 Shore Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Joppa		9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Joppa	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 754 Shore Drive		10f. ZIP CODE: 21085	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic	16b. KIND OF BUSINESS/INDUSTRY: Auto	
17. FATHER'S NAME (First, Middle, Last): John James Dunne		18. MOTHER'S NAME (First, Middle, Maiden Surname): Winifred Cecelia Burns	
19a. INFORMANT'S NAME (Type/Print): Nancy W. Phillips		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 754 Shore Drive, Joppa, Md. 21085	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Moreland Memorial Park Cemetery	20c. LOCATION — City or Town, State: , Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Carcinoma lung	6 mo
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Emphysema	yrs,
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D18648	29d. DATE SIGNED (Month, Day, Year): ▶12-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Louis O. Olsen 1020 Old N. 24 Rd Balto md 21224		
31. DATE FILED (Month, Day, Year): JAN 02 90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37419

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Fanny C. Dowdy			2. DATE OF DEATH (Month, Day, Year): 12 - 23 - 89	3. TIME OF DEATH: 10 00 M
4. SOCIAL SECURITY NUMBER: 579-07-3924	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 18, 1896	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Bradford Oaks		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Suitland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3919 Park Blvd.		10f. ZIP CODE: 20746	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Daniel Trent		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma Beard	
19a. INFORMANT'S NAME (Type/Print): Ila Mower	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3919 Park Blvd, Suitland, MD. 20746		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Boyce E. Wilhelm	22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland Rd. Suitland, MD. 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	1wk.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: DO 7348	29d. DATE SIGNED (Month, Day, Year): ▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R.M. NEDZBALA MD 11701 Livingston Rd. Fort Washington Md. 20744

31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

(10)

89 37420

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUBY DAVIS			2. DATE OF DEATH (Month / Day / Year): 12 / 30 / 89	3. TIME OF DEATH: 8:20AM M
4. SOCIAL SECURITY NUMBER: 212 38 4196	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8/23/06	8. BIRTHPLACE (State or Foreign Country): Minn.
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE'S
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Bowie		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12419 Sarah Lane		10f. ZIP CODE: 20715		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: NO	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: NO		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ------- College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home		
17. FATHER'S NAME (First, Middle, Last): Axel Brown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Amanda Holmquist		
19a. INFORMANT'S NAME (Type/Print): Corinne Strickler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14202 Manorvale Road Rockville Md. 20853		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery		20c. LOCATION — City or Town, State: Arlington Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres.		22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Pulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Congestive Heart failure / Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Arteriosclerotic Cardio Vascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebral Vascular Accident

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Linnea Whitby MD	29c. LICENSE NUMBER: D17162	29d. DATE SIGNED (Month, Day, Year): 1/4/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linnea Whitby MD 9556 CRAIN Hwy Upper Marlboro, MD 20772

31. DATE FILED (Month, Day, Year): JAN 09 '90	32. REGISTRAR'S SIGNATURE: Gilbert Davidson Randall

DHMH-16 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 may be retained by the hospital or attending physician. 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

(R)

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89 37421

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNEST ELLIS EGERMAN

2. DATE OF DEATH (Month, Day, Year): 12-28-1989

3. TIME OF DEATH: 7:00 AM

4. SOCIAL SECURITY NUMBER: 100-16-8155

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH: 4/28/1922

8. BIRTHPLACE (State or Foreign Country): YONKERS N.Y.

9a. FACILITY NAME (If not institution, give street and number): 3110 FALLSTON AVE. Calverton Md.

9b. CITY, TOWN OR LOCATION OF DEATH: CALVERTON MD.

9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: MD.

10b. COUNTY: P.G.

10c. CITY, TOWN OR LOCATION: CALVERTON

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 3110 FALLSTON AVE.

10f. ZIP CODE: 20705

10g. CITIZEN OF WHAT COUNTRY?: u.s.a.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: W.W.2

13. WAS DECENDENT OF NISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12 YRS
College (1-4 or 5+): ----

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUSINESS OWNER

16b. KIND OF BUSINESS/INDUSTRY: CARPET CONSULTING

17. FATHER'S NAME (First, Middle, Last): JACOB EGERMAN

18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE NATHAN

19a. INFORMANT'S NAME (Type/Print): JOHN EGERMAN

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 NORMANDY SQ. CT.; SSPG., MD. 20906

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SUBURBAN CREMATORY

20c. LOCATION — City or Town, State: SILVER SPRING MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Medard Lavoie

22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEM CHPS., INC. 1170 ROCKVILLE PK. ROCKVILLE MD. 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Amyotrophic lateral sclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Howard Silby MD

29c. LICENSE NUMBER: D08169

29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR.HOWARD SILBY:5454 WISCONSIN AVE #1750:CHEVY CHASE,MD 20815

31. DATE FILED (Month, Day, Year): JAN 3 '90

32. REGISTRAR'S SIGNATURE: Jane Williamson Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible]. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed [illegible] director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal [illegible]

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12+1

89 37422

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Flora Elizabeth Elbourn			2. DATE OF DEATH (Month, Day, Year): December 24, 1989	3. TIME OF DEATH: 8:22PM M
4. SOCIAL SECURITY NUMBER: 220-26-8089	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-11-31	8. BIRTHPLACE (State or Foreign Country): ROCK HALL MD.
9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Anne's Hospital Inc.		9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown	9c. COUNTY OF DEATH: Kent	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: KENT	10c. CITY, TOWN OR LOCATION: ROCK HALL	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: RT#1 Box 284		10f. ZIP CODE: 21661	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): WILLARD T. ASHLEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH ATKINSON	
19a. INFORMANT'S NAME (Type/Print): JANET CLARK		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 59 Rock Hall MD. KENT, CO.	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WESLEY CHAPEL CEMETERY	20c. LOCATION — City or Town, State: KENT ROCK HALL MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas K. Helfenstein		22. NAME AND ADDRESS OF FACILITY: TOM HELFENSTEIN FUNERAL HOME P.A. ROCK HALL, MD. 21661	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiogenic Shock.	3 hrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Acute extensive Myocardial Infarction	6-8 hrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Complete Heart Block
Dehydration & Ketosis
Hyperglycemia

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George M Young MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 12/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): GEORGE M. YOUNG	KENT & QUEEN ANNES HOSP. CHESTERTOWN MD 21620	
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-16 Rev 1/89

89 37423

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES FREDERICK EDSON, SR.		2. DATE OF DEATH (Month, Day, Year): December 25, 1989	3. TIME OF DEATH: 2:05 a.M
4. SOCIAL SECURITY NUMBER: 579-36-4303	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT 30, 1928
8. BIRTHPLACE (State or Foreign Country): Massachusetts			
9a. FACILITY NAME (If not institution, give street and number): 10210 Parkwood Drive	9b. CITY, TOWN OR LOCATION OF DEATH: Kensington	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Kensington	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 10210 Parkwood Drive	10f. ZIP CODE: 20895	10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 1947 - 1949	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Real Estate Assessor	16b. KIND OF BUSINESS/INDUSTRY: D. C. Government	
17. FATHER'S NAME (First, Middle, Last): Stephen Reuben Edson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Bridgette McWilliams		
19a. INFORMANT'S NAME (Type/Print): William C. Edson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18307 Leman Lake Drive Olney, Maryland 20832		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven	20c. LOCATION — City or Town, State: Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Keith L. Wilson	22. NAME AND ADDRESS OF FACILITY: JOSEPH GAWLER'S SONS 5130 Wisconsin Avenue, NW Washington, DC 20016		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LEIOMYOSARCOMA	3 YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: SPINAL CORD COMPRESSION; BRONCHITIS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel Rosenblum MD | 29c. LICENSE NUMBER: DO 4766 | 29d. DATE SIGNED (Month, Day, Year): ▶ December 26, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Daniel Rosenblum MD 10400 Conn. Avenue Kensington, Maryland 20895

31. DATE FILED (Month, Day, Year): DEC 27 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH-18 Rev 1/89

89 37424

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): IDA BLANCHE FRANKLIN			2. DATE OF DEATH (Month, Day, Year): DEC. 25 1989	3. TIME OF DEATH: 3:00 AM M
4. SOCIAL SECURITY NUMBER: 577-60-3850	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 10-22-1898	8. BIRTHPLACE (State or Foreign Country): N.Y.C.
9a. FACILITY NAME (If not institution, give street and number): BETHESDA RETIREMENT/NURSING CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVY CHASE	9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: CHEVY CHASE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 8700 JONES MILL RD.		10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YRS; College (1-4 or 5+): 2 YRS	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECY- RETIRED	16b. KIND OF BUSINESS/INDUSTRY: U.S. GOVT.		
17. FATHER'S NAME (First, Middle, Last): JOSEPH FINKELSTEIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): FANNIE STEINBERG		
19a. INFORMANT'S NAME (Type/Print): MAX M. GOLDBERG ESQ.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10300 W. BAY HARBOR DR. #6-B BAY HARBOR ISLSFLA 33154		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. LEBANON CEM.	20c. LOCATION — City or Town, State: ADELPHI MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary M. Gins		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PK. ROCKVILLE MD 20852		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE HEART FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark H. Eig	29c. LICENSE NUMBER: D024886	29d. DATE SIGNED (Month, Day, Year): 12/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mark H. Eig, M.D. 9801 Georgia Ave., #3-40, Silver Spring, Maryland 20902

31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37425

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 ... hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director ... attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAUL V. FINEGAN		2. DATE OF DEATH (Month, Day, Year): 12-31-89	3. TIME OF DEATH: 1035 P M
4. SOCIAL SECURITY NUMBER: 214-42-4120	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 11-04-05
8. BIRTHPLACE (State or Foreign Country): VA.			
9a. FACILITY NAME (If not institution, give street and number): BROOKE GROVE NURSING HOME	9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY	9c. COUNTY OF DEATH: MONT.	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: OLNEY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 17608 PRINCE EDWARD DR.	10f. ZIP CODE: 20832	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DIRECTOR	16b. KIND OF BUSINESS/INDUSTRY: US POSTAL SERVICE
17. FATHER'S NAME (First, Middle, Last): JAMES N. FINEGAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNE F. FERRITER	
19a. INFORMANT'S NAME (Type/Print): PAULA F. PRAHINSKI		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17608 PRINCE EDWARD DR. OLNEY MD. 20832	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): metropolitan crematory	20c. LOCATION — City or Town, State: ALEXANDRIA, VIRGINIA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert Mackey		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIV. BLVD. W. SIL. SPG. MD. 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC MELANOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T E Howe	29c. LICENSE NUMBER: D33700	29d. DATE SIGNED (Month, Day, Year): 1-1-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): TED E. HOWE MD OLNEY MARYLAND		
31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall	

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OHMH-18 Rev 1/89

89 37426

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MINNIE Marie FISCUS

2. DATE OF DEATH (Month, Day, Year): 12 27 89

3. TIME OF DEATH: 1230 A M

4. SOCIAL SECURITY NUMBER: 170-22-6504

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 88 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Aug. 30, 1901

8. BIRTHPLACE (State or Foreign Country): Pennsylvania

9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Nursing Home

9b. CITY, TOWN OR LOCATION OF DEATH: Laurel

9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Prince George's

10c. CITY, TOWN OR LOCATION: Hyattsville

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2108 Charleston Place

10f. ZIP CODE: 20783

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 8th Grade
College (1-4 or 5+): ---------

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Isaiah Stahl

18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary A. Melville

19a. INFORMANT'S NAME (Type/Print): Isaiah D. Fiscus (Son)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2108 Charleston Place, Hyattsville, Md. 20783

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fairmont Cemetery

20c. LOCATION — City or Town, State: Cooktownship, Pennsylvania

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]

22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A.
4739 Baltimore Ave. Hyattsville, Md. 20781

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Arteriosclerotic Cardiovascular Disease and
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes mellitus and
DUE TO (OR AS A CONSEQUENCE OF):
d. Senile Dementia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
multiple cerebrovascular accident with left Hemiplegia, Totally Bed ridden

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

28. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined

26a. DATE OF INJURY (Month, Day, Year)

26b. TIME OF INJURY M

26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

26d. DESCRIBE HOW INJURY OCCURED

28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MKarim MD

29c. LICENSE NUMBER: D-18895

29d. DATE SIGNED (Month, Day, Year): ▶ 12-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD

31. DATE FILED (Month, Day, Year): DEC 29 '89

32. REGISTRAR'S SIGNATURE: Lydia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(6)

89 37427

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roger G Flynn			2. DATE OF DEATH (Month, Day, Year): December 20 1989	3. TIME OF DEATH: 9:50 A M
4. SOCIAL SECURITY NUMBER: 005 12 7048	5. SEX: 1 [X] M 2 [ ] F (Male)	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/3/1912	8. BIRTHPLACE (State or Foreign Country): New Hampshire
9a. FACILITY NAME (If not institution, give street and number): Webb's Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Betterton		9c. COUNTY OF DEATH: Kent
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Chestertown		10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 107 Mile Tree Village		10f. ZIP CODE: 21620		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced (Married)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES: no	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: no		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Executive Air Transport	16b. KIND OF BUSINESS/INDUSTRY: Asso.		
17. FATHER'S NAME (First, Middle, Last): Joseph S. Flynn		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minna Sullivan		
19a. INFORMANT'S NAME (Type/Print): Esith Flyn		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 107 Birch Run Mile Tree Village Chestertown, Md		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) Cremation	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory Inc. 12/21/89	20c. LOCATION — City or Town, State: Baltimore, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells	22. NAME AND ADDRESS OF FACILITY: J. Willis Wells	P.O. Box # 264 Chestertown, Md. 21620		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic obstructive pulmonary disease	yr
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CARCINOMA OF LARYNX

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hans P Noll MD	D10001	▶ 12-20-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
for Susan Ross Chestertown, Md. 21620

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 20 '89	Julia Davidson-Randall

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DHMH-16 Rev 1/89

89 37428

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Paul Calvin Falk			2. DATE OF DEATH (Month, Day, Year): 12 30 89	3. TIME OF DEATH: 820 A M
4. SOCIAL SECURITY NUMBER: 215-05-1269	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07/16/15	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Halethorpe		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1732 Winans Avenue		10f. ZIP CODE: 21227		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Postmaster	16b. KIND OF BUSINESS/INDUSTRY: Federal Govt.		
17. FATNER'S NAME (First, Middle, Last): Paul Falk		18. MOTNER'S NAME (First, Middle, Maiden Surname): Ada Lester		
19a. INFORMANT'S NAME (Type/Print): Irene G. Falk	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1732 Winans Avenue, Halethorpe, Maryland 21227			
20a. METNOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Dorsey, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:	22. NAME AND ADDRESS OF FACILITY: Ambrose Funeral Home, Inc. 1328 SUlphur Spring , Arbutus, Md. 21227			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, Dr complications that caused the death. Dd ndt enter the mode of dying, such as cardiac Dr respiratory arrest, ehock, or heert failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. Acute Leukemia	4days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentielly list conditions, if eny, leading to immediete ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Myelodysplastic Syndrome	2mos
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significent conditions contributing to death but not resulting in the underlying ceuse given in Part I.: Paroxysmal Atrial Tachycardia

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Nome 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATN: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE NOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dus to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Eugene [illegible] M.D. Mass Staff	29c. LICENSE NUMBER: D38770	29d. DATE SIGNED (Month, Day, Year): 12-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eugene F FINAN Jr 900 Caton Ave Baltimore 21229		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

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89 37429

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PATRICK EMMETT FAHEY			2. DATE OF DEATH (Month - Day - Year): 12 - 29 - 1989	3. TIME OF DEATH: 7:00 PM M
4. SOCIAL SECURITY NUMBER: 217144435	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09-06-1896	8. BIRTHPLACE (State or Foreign Country): WV
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: ALLEGANY COUNTY	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Allegany	10c. CITY, TOWN OR LOCATION: Cumberland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 404½ N. Centre Street		10f. ZIP CODE: 21502	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): independent grocer	16b. KIND OF BUSINESS/INDUSTRY: grocery store		
17. FATHER'S NAME (First, Middle, Last): John Fahey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Carney		
19a. INFORMANT'S NAME (Type/Print): Gladys F. Fahey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 404½ N. Centre Street, Cumberland, MD 21502		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Patricks Cemetery	20c. LOCATION — City or Town, State: Cumberland, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James F. Scarpelli		22. NAME AND ADDRESS OF FACILITY: Scarpelli Funeral Home, 108 Virginia Ave., Cumberland, MD 21502		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Renal Failure	4 wk
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Sepsis	8 wk
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Carcinoma of Common Bile Duct	2 mo ±
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ASCVD Myocardial Infarct 4 mo + Post op.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Victor E. Mazzocco MD	D 07135	▶ 1-2-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. EUGENE V. MAZZOCCO BMG 912 SETON DRIVE CUMBERLAND, MD. 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 1990	Gina Davidson-Randall

DHMH-16 Rev 1/89

89 37430

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNest F. Friesland
2. DATE OF DEATH: MONTH Dec DAY 31, YEAR 1989
3. TIME OF DEATH: 7:20 PM
4. SOCIAL SECURITY NUMBER: 245-01-8988
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/6/1909
8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): Harford Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Havre de Grace
9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: North East
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 57 Cederhill Circle
10f. ZIP CODE: 21901
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic
16b. KIND OF BUSINESS/INDUSTRY: Aircraft
17. FATNER'S NAME (First, Middle, Last): James Friesland
18. MOTNER'S NAME (First, Middle, Maiden Surname): Lillie Bishop
19a. INFORMANT'S NAME (Type/Print): Roy G. Friesland
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 431 Red Hill Road Conowingo, MD 21918
20a. METNOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): R.A. Ferris & Co
20c. LOCATION — City or Town, State: West Chester, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert T. Crouch
22. NAME AND ADDRESS OF FACILITY: Crouch Funeral Home 127 S. Main St. North East, MD 21901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA. — 1 WK

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ISCHEMIC HEART DISEASE.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: K Mithani MD.
29c. LICENSE NUMBER: D 32609
29d. DATE SIGNED (Month, Day, Year): 1/1/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KAMRUDIN MITHANI . 433 GIRARD ST. HAVRE DE GRACE . MD 21078
31. DATE FILED (Month, Day, Year): JAN 03 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMM-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. (Sec. 5) may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

89 37431

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jean B. Foust			2. DATE OF DEATH: MONTH 12 DAY 26 YEAR 89	3. TIME OF DEATH: 2:40P M
4. SOCIAL SECURITY NUMBER: 256-34-1619	5. SEX: 1 ☐ M 2 ☒ F	5. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 3, 1928	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): 108 Kenilworth Park Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Towson	9c. COUNTY OF DEATH: Baltimore	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Towson	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 108 Kenilworth Park Drive		10f. ZIP CODE: 21204	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Home making	
17. FATHER'S NAME (First, Middle, Last): William H. Walden		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Mary Thomas	
19a. INFORMANT'S NAME (Type/Print): Sydney L. DeMilt	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1102 Candor Court Towson Md 21204		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Yorktowne Cremation Service	20c. LOCATION — City or Town, State: York PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Glenn E. Geisler	22. NAME AND ADDRESS OF FACILITY: 53 MAIN St. Glen Rock, Pa. 17327 Geisler Funeral Home Inc		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Gunshot wound to head	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic alcoholism

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-26-89	28b. TIME OF INJURY: 5:00PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURRED: Subject shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 108 Kenilworth Park Drive, Towson, MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant	111 Penn St., Baltimore, MD 21201	
31. DATE FILED (Month, Day, Year): JAN 17 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37432

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial/transit permit. Copies 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Copies 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Nora	May	FOX	Dec. 28, 1989	230 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
220-40-2186	1 ☐ M 2 ☒ F	81 YRS.			Aug. 15, 1908	West Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Garrett County Memorial Hospital	Oakland	Garrett

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Garrett	Oakland	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Star Route #2, Box 118	21550	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
6th		Housewife	Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Uriah Coleman Phillips	Daisy Ellen Shahan

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Minnie Upole	P.O. Box 266, Oakland, Maryland 21550

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Garrett Co. Memorial Gardens	Oakland, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Bradley A. Stewart	Stewart Funeral Home 32 S. Second St., Oakland, MD 21550

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute thrombophlebitis (RT) leg	5 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular insufficiency

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☑ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☑ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D-15333	▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Dr. Thomas Johnson, MD	311 N. Fourth St., Oakland, Maryland 21550

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 90	[signature]

3

DHMH-16 Rev 1/89

89 37433

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julia fugitt / JULIA ADA FUGITT			2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 89	3. TIME OF DEATH: 10 16 P M
4. SOCIAL SECURITY NUMBER: 578-24-5249	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): X 78 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN 17, 1911	8. BIRTHPLACE (State or Foreign Country): WASHINGTON DC
9a. FACILITY NAME (If not institution, give street and number): Southern Md Hosp Ctr		9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: PG	PRINCE GEOR

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: WALDORF	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO
10e. STREET AND NUMBER: 3302 PINEFIELD LANE		10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9TH GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CLERK	16b. KIND OF BUSINESS/INDUSTRY: US GOVERNMENT	
17. FATHER'S NAME (First, Middle, Last): JAY VANCE WOODRUFF	18. MOTHER'S NAME (First, Middle, Maiden Surname): ADA ELIZABETH MASON		
19a. INFORMANT'S NAME (Type/Print): HELEN M. SHIMANSKY	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1558 FARLWO AVE., CROFTON, MD 21114		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WASHINGTON NATIONAL CEMETERY	20c. LOCATION — City or Town, State: SUITLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: THE HUNTT FUNERAL HOME, INC. P.O. BOX 156, WALDORF, MARYLAND 20604-0156		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO pulmonary Arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

c. Hypertensive Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Linda Whitby MD	29c. LICENSE NUMBER: D17162	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda Whitby MD 9556 Crain Hwy Upper Marlboro, MD		
31. DATE FILED (Month, Day, Year): JAN 03 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37434

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM G FLEISCHMAN / William G. Fleischman	2. DATE OF DEATH: MONTH 12 DAY 31 YEAR 89 / 12 31 89	3. TIME OF DEATH: 0711 AM / 0711 A M	
4. SOCIAL SECURITY NUMBER: 214-07-9036	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/7/1911
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge	9c. COUNTY OF DEATH: Dorchester	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1049 Cambridge Beltway	10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: US	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tire Dealer	16b. KIND OF BUSINESS/INDUSTRY: Automotive	
17. FATNER'S NAME (First, Middle, Last): Frank Fleischman	18. MOTNER'S NAME (First, Middle, Maiden Surname): Grace Page		
19a. INFORMANT'S NAME (Type/Print): Mae C. Fleischman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1049 Cambridge Beltway		
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorchester Memorial Park	20c. LOCATION — City or Town, State: Cambridge, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Andrew J Thomas	22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home / 700 Locust St. Cambridge, Md. 21613		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST 2DEGREE A S C V D / CARDIOPULMONARY ARREST 2° ASCVD

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AMILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael B [illegible] M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 12-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATN (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

89 37435

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DOROTHEA FONTENOT			2. DATE OF DEATH (Month, Day, Year): 12/23/89	3. TIME OF DEATH: 12:15 AM
4. SOCIAL SECURITY NUMBER: 218-20-8921	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-26-1926	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Baltimore VAMC		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Cal.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: California	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: PO Box 3457	10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY?	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Chauncey Atkins		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olivia Sampson	
19a. INFORMANT'S NAME (Type/Print): Enez Grubb		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 816 Bradley Ave. Cambridge, MD. 21613	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion Cemetary	20c. LOCATION — City or Town, State: East New Market, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith		22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services PO Box 928 Hurlock, Md. 21643	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory Arrest — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Left Leg Gangrene — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Large Cell CA of Lung, Stg IIIB. — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypercoagulable State.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J DeLeon MD 0328	29c. LICENSE NUMBER: 090-50-0892	29d. DATE SIGNED (Month, Day, Year) ▶ 12/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 22 S. Greene St Balt MD 21201		
31. DATE FILED (Month, Day, Year): JAN - 9 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 37436

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLIAM P. FORKER JR.		2. DATE OF DEATH: MONTH 12 DAY 30 YEAR 89	3. TIME OF DEATH: 0710 AM M
4. SOCIAL SECURITY NUMBER: 175-10-2300	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 1, 1913
8. BIRTHPLACE (State or Foreign Country): Pottstown, PA			
9a. FACILITY NAME (If not institution, give street and number): University of Maryland Medical Ctr.	9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore	9c. COUNTY OF DEATH:	

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: York	10c. CITY, TOWN OR LOCATION: York	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2787 Carnegie Road, Apt. 103	10f. ZIP CODE: 17402	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES: XX	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tool & Die Maker	16b. KIND OF BUSINESS/INDUSTRY: Litton Inds.	
17. FATHER'S NAME (First, Middle, Last): William P. Forker, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah O. Kerr	
19a. INFORMANT'S NAME (Type/Print): Mary Ann French		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 919 Dunellen Dr., Towson, MD 21204	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Rose Cemetery	20c. LOCATION — City or Town, State: York, PA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Semmel - Supervisor		22. NAME AND ADDRESS OF FACILITY: Wm. J. Workinger Funeral Home, Inc. 849 East Market Street, York, PA 17403	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	2 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ACUTE LEUKEMIA	3 DAYS.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael [illegible]	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): UNIVERSITY OF MARYLAND CANCER CENTER 22 S. GREENE ST BALTIMORE MD 21201

31. DATE FILED (Month, Day, Year): JAN 16 1990	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-16 Rev 1/89

89 37437

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BASCOMBE M. FOSTER			2. DATE OF DEATH (Month / Day / Year): 12 / 31 / 89	3. TIME OF DEATH: 12:45 A M
4. SOCIAL SECURITY NUMBER: 577-18-7700	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 23, 1910	8. BIRTHPLACE (State or Foreign Country): NORTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE'S
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: LANHAM		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7310 FINNS LANE		10f. ZIP CODE: 20706		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9+ / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PIANO TECHNICIAN		16b. KIND OF BUSINESS/INDUSTRY: MUSIC
17. FATHER'S NAME (First, Middle, Last): CHARLES FOSTER			18. MOTHER'S NAME (First, Middle, Maiden Surname): ADGIE WOODELL	
19a. INFORMANT'S NAME (Type/Print): LILA M. FOSTER (SPOUSE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7310 FINNS LANE, LANHAM MD 20706		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY		20c. LOCATION — City or Town, State: BRENTWOOD, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: RENDON-HALE FUNERAL HOME 9013 ANNAPOLIS RD. LANHAM, MD 20706		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septic Shock	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pancytopenia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Multiple Myeloma, Leukemia, Anemia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Chemotherapy + Radiation Therapy	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible]	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4410 44th Ave Cheverly MD 20784		
31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37438

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. ... by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral ... be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner ... notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUSSELL EARL GALLAGHER			2. DATE OF DEATH (Month, Day, Year): DEC 28 1989	3. TIME OF DEATH: 5:50 P M
4. SOCIAL SECURITY NUMBER: 187-62-0097	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 20 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 20 1969	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): NATIONAL NAVAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: PA	10b. COUNTY: CHESTER	10c. CITY, TOWN OR LOCATION: WEST CHESTER	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 97 CRAB APPLE LANE	10f. ZIP CODE: 19380	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES	

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: 1988-PRESENT	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U. S. NAVY	16b. KIND OF BUSINESS/INDUSTRY: DEFENSE	
17. FATHER'S NAME (First, Middle, Last): ROBERT EARL GALLAGHER, JR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): PAULA MARIE KILPATRICK	
19a. INFORMANT'S NAME (Type/Print): ROBERT E.GALLAGHER,JR.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 97 CRAB APPLE LANE, WEST CHESTER, PA 19380		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NORTHWOOD CEMETERY	20c. LOCATION — City or Town, State: DOWNINGTOWN, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.W. Chambers MO0091	22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. INC., RIVERDALE, MD. 20737		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE MYELOGENOUS LEUKEMIA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S Hager LCDR, MC USN	29c. LICENSE NUMBER: 160037-N4	29d. DATE SIGNED (Month, Day, Year): 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S.HAGER, LCDR, MC, USN	NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20814-5011	
31. DATE FILED (Month, Day, Year): JAN 4 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

2+1

DHMH-16 Rev 1/89

89 37439

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PEARLE P. GRIFFITH				2. DATE OF DEATH (Month / Day / Year): 12 / 4 / 89		3. TIME OF DEATH: 2.25 AM
4. SOCIAL SECURITY NUMBER: 229-01-0606	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 86 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb/8/1903	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON		9c. COUNTY OF DEATH: PRINCE GEORGES	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Prince George	New Carrollton	1 ☐ YES 2 ☒ NO XX

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
5806 Runford Drive	20784	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		clerk	laundry

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Samuel Ward	Bessie Jane Smith

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Dorris Parent	5806 Runford Drive New Carrollton MD 20784

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Resurrection	Clinton MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Robert E. Wilhelm	Robert E. Wilhelm Funeral Home, INC. Suitland MD 20746

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aspiration pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Fracture of R hip
Anemia
Senile dementia

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ ND	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ ND	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	11.29.89	6:30P M	1 ☐ YES 2 ☒ NO	SUBJECT FELL

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
NURSING HOME	7520 Surratts Rd. CLINTON

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

CERTIFICATION APPROVED BY MEDICAL EXAMINER

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D		▶ 12/4/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 05 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37440

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 ... use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LENORE GRIMLEY		2. DATE OF DEATH (Month, Day, Year): DEC. 25, 1989	3. TIME OF DEATH: 8:25 P M
4. SOCIAL SECURITY NUMBER: 097-32-2836	5. SEX: 1 ☐ M 2 ☒ F (XX)	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/3/1901
8. BIRTHPLACE (State or Foreign Country): Austria			
9a. FACILITY NAME (If not institution, give street and number): Potomac Valley Nursing Center	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Potomac	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 5 Lakenheath Court	10f. ZIP CODE: 20854	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed (XX) 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO (X) IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO (XX) Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher-Retired	16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Philip Schnoll		18. MOTHER'S NAME (First, Middle, Maiden Surname): Golda Wolmouth	
19a. INFORMANT'S NAME (Type/Print): Dr. Philip Grimley (son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5 Lakenheath Ct., Potomac, MD 20854	
20a. METHOD OF DISPOSITION: 1 ☒ Burial (XX) 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Riverside Cemetery	20c. LOCATION — City or Town, State: Lodi, N.J.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary M. Lin		22. NAME AND ADDRESS OF FACILITY: Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. DEHYDRATION	1 week
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ORGANIC BRAW SYNDROME	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ARTERIOSCLEROSIS
FEVER, source not determined

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO (X)

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home (X) 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural (X) 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN (X): To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hubert J. Alpert, MD ATTENDING	D 00143 - MD	DEC. 25, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HUBERT J. ALPERT, M.D. 8630 FENTON STREET SILVER SPRING, MD 20910

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	Julia Davidson-Randolph

6

DHMH-18 Rev 1/89

89 37440

89 37441

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEN PURSE GALE				2. DATE OF DEATH (Month, Day, Year): Dec/ 30 1989	3. TIME OF DEATH: 11:10 P M
4. SOCIAL SECURITY NUMBER: 271 09 2792	5. SEX: Male (XX 1 M 2 F)	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug 5, 1907	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): At Home Rte # 3 Box # 12			9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown, Md. 21620		9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: RFD CHestertown	10d. INSIDE CITY LIMITS? (XX 1 YES 2 NO)
10e. STREET AND NUMBER: Rte # 3 Box # 12		10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: Married (XX 2) (1 Never Married 2 Married 3 Widowed 4 Divorced)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (XX 1 YES 2 NO) IF YES, GIVE WAR OR DATES: Yes. Army WW 2	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) (XX 2 NO) Specify: no	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 +	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Business and Federal Executive	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Hoyt Willoughby Gale		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Purse	
19a. INFORMANT'S NAME (Type/Print): Ellen Gale (wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RFD Country Club Chestertown, Md. 21620 Rte # 3	
20a. METHOD OF DISPOSITION (XX 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)): Burial	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St/ Paul's Cemetery (Jan 4, 1990)	20c. LOCATION — City or Town, State: near Chestertown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells	22. NAME AND ADDRESS OF FACILITY: J. Willis Wells P.O. Box # 264 C hestertown Md. 21620		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ALZHEIMER'S DISEASE

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? (1 YES 2 NO)	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (1 YES 2 NO)

25. WAS CASE REFERRED TO MEDICAL EXAMINER? (1 YES 2 NO)	26. PLACE OF DEATH (Check only one) HOSPITAL: (1 Inpatient 2 ER/Outpatient 3 DOA) OTHER: (4 Nursing Home 5 Residence 6 Other (Specify))			
27. MANNER OF DEATH (1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined)	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? (1 YES 2 NO)	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 (X) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ( ) MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John C. Seymour	29c. LICENSE NUMBER: D13824	29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John C. Seymour, M.D. Chestertown, Md. 21620

31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

15 1990

DHMH-16 Rev 1/89

89 37442

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BYRON ALBERT GLOVIER				2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH: 4:45 P M
4. SOCIAL SECURITY NUMBER: 167-22-5728	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): NOV. 24, 1928	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Annapolis	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 220-A Hill Top Lane, @202		10f. ZIP CODE: 21403	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer	16b. KIND OF BUSINESS/INDUSTRY: Civil Service - U.S. Navy
17. FATHER'S NAME (First, Middle, Last): Clarence M. Glovier		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna A. Sebring	
19a. INFORMANT'S NAME (Type/Print): Cynthia A. Parks		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harford Memorial Gardens	20c. LOCATION — City or Town, State: Aldino, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO — Head only	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

30a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

30b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin	30c. LICENSE NUMBER: OCME	30d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89

30e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Julia C. Goodin, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 v1

31. DATE FILED (Month, Day, Year): JAN 02 90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37443

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALBERT EDWARD GILL			2. DATE OF DEATH (Month, Day, Year): DECEMBER 24 89	3. TIME OF DEATH: 6:35 A M
4. SOCIAL SECURITY NUMBER: 578-07-0491	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 4, 1904	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): GLADY'S NOONE SPELLMAN NUR. CARE CTR.		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE'S
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 3202 WELLER ROAD		10f. ZIP CODE: 20906		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PAINTER	16b. KIND OF BUSINESS/INDUSTRY: STATE GOVERNMENT		
17. FATHER'S NAME (First, Middle, Last): HARRY GILL		18. MOTHER'S NAME (First, Middle, Maiden Surname): DAISY KISNER		
19a. INFORMANT'S NAME (Type/Print): ALMA L. GILL WIFE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3202 WELLER ROAD SILVER SPRING, MARYLAND 20906		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR HILL CEMETERY	20c. LOCATION — City or Town, State: SUITLAND, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert N Zachary	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pneumonia, aspiration DUE TO (OR AS A CONSEQUENCE OF):	days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):	months
c.	Malignant melanoma DUE TO (OR AS A CONSEQUENCE OF):	months
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D22780	29d. DATE SIGNED (Month, Day, Year): 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible] MD 7500 Greenway Ctr Dr. Greenbelt MD 20770

31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Lichia Davidson-Randall

DHMH-18 Rev 1/89

6+1

89 37444

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID LOWELL GARRETT					2. DATE OF DEATH (Month, Day, Year): DECEMBER 24, 1989	3. TIME OF DEATH: 8:35 AM
4. SOCIAL SECURITY NUMBER: 215-36-3307	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): APRIL 7, 1938	8. BIRTHPLACE (State or Foreign Country): WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): 4300 COLLEGE HEIGHTS DRIVE			9b. CITY, TOWN OR LOCATION OF DEATH: UNIVERSITY PARK		9c. COUNTY OF DEATH: PRINCE GEORGES	
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY: PRINCE GEORGES		10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO	
10e. STREET AND NUMBER: 9203 NEW HAMPSHIRE AVENUE #303			10f. ZIP CODE:		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PHYSICIST		16b. KIND OF BUSINESS/INDUSTRY: NAVAL RESEARCH LAB.		
17. FATHER'S NAME (First, Middle, Last): JAMES R. GARRETT			18. MOTHER'S NAME (First, Middle, Maiden Surname): LULA D. DENNISON			
19a. INFORMANT'S NAME (Type/Print): LULA D. GARRETT			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4300 COLLEGE HEIGHTS DRIVE UNIVERSITY PARK, MD. 20782			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MARSHVILLE CEMETERY		20c. LOCATION — City or Town, State: MARSHVILLE, W.VA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]			22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL.SPR., MD. 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Carcinoma of lung.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hypercalcemia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: 1412	29d. DATE SIGNED (Month, Day, Year): 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): NICHOLAS L. CHRISTOPHER, M.D. 3301 NEW MEXICO AVE., N.W. WASHINGTON, DC 20016		
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

12

OHMH-16 Rev 1/89

89 37445

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Gay~~ Norman Lester GAY, Sr.			2. DATE OF DEATH (Month, Day, Year): Dec 26 1989	3. TIME OF DEATH: 9:40 PM
4. SOCIAL SECURITY NUMBER: 220-28-3271	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 18, 1932	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Sharpsburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 108 S. Mechanic St.		10f. ZIP CODE: 21782	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Harvey Norman Gay		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Hazel McGowan	
19a. INFORMANT'S NAME (Type/Print): Mary L. Gay		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 108 S. mechanic St. Sharpsburg, MD 21782	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Samples Manor Cemetery	20c. LOCATION — City or Town, State: Dargan, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: OSBORNE FUNERAL HOMES P.O. Box # 348 Williamsport, MD 21795	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Wide spread metastasis	1 mo
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Carcinoma of esoph	9 mo
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Harold R Tasker MD	29c. LICENSE NUMBER: D 12194	29d. DATE SIGNED (Month, Day, Year): ▶ 12-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Harold R Tasker, JR MD 343 Mill ST Hagerstown Md		
31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37446

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Johnnie	Lee	GREENLEAF	December 22, 1989	3:34 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
265-54-1786	1 ☐ M 2 ☒ F	52 YRS.			5-3-37	Florida

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
AMI Doctors' Hospital 8118 Goodluck Rd.	Lanham, Maryland	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince Georges	Laurel	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
410 Marshall ave. Apt(E)	20707	U.S.A

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO Specify:	Specify: Black

15. DECEOENT'S EDUCATION (Specify only highest grade completed)		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Clerk	Aritron Corp.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
John Evans	Elizabeth Johnson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sharon Greenleaf (Daughter)	410 Marshall Ave. Laurel, Md. 20707

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Harmony Men Park	Landover Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Henry C. Morton 618	Wash., D.C. Gorman Funeral Serv. 3605 14th St. N.W.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio-Pulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Viral Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cardiomyopathy	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Louis Steinberg MD	D12015	▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Louis Steinberg 6492 Landover Rd Landover Md 20785

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 3 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Page 4 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37447

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): STELLA PAOLA GUIO					2. DATE OF DEATH (Month, Day, Year): DECEMBER 23, 1989	3. TIME OF DEATH: 7:35 P M
4. SOCIAL SECURITY NUMBER: 213-25-4741	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 5 mons YRS.	IF UNDER 1 YEAR: MONTHS 4 DAYS 29	IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 24, 1989	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 14207 GEORGIA AVENUE #T-1			9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING		9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT						
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY		10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: 14207 GEORGIA AVENUE #T-1			10f. ZIP CODE: 20906		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): MIGUEL RAMIRO GUIO					18. MOTHER'S NAME (First, Middle, Maiden Surname): NUBIA STELLA TELLEZ	
19a. INFORMANT'S NAME (Type/Print): MIGUEL GUIO FATHER			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14207 GEORGIA AVE. #T-1 SILVER SPRING, MD. 20906			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY		20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sara D Bland			22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, auch as cardiac or reapiratory arrest, ahock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC UNDIF. SARCOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initieted events resulting in death) LAST	b. CARDIO RESPIRATORY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 5 ☐ Pending Investigation 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
N. Movassaghi, M. D.	D30068	▶ 12/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): N. MOVASSAGHI, M.D. CHILDRENS HOSPITAL NATIONAL MEDICAL CENTER WASHINGTON, D.C.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 28 '89	Julia Davidson-Randell

DHMH-18 Rev 1/89

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 37448

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): eddie M. Godwin, JR.			2. DATE OF DEATH: MONTH 12 DAY 24 YEAR 89	3. TIME OF DEATH: 430 AM M
4. SOCIAL SECURITY NUMBER: 577-42-3215	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT. 24, 1933	8. BIRTHPLACE (State or Foreign Country): WASHINGTON, D.C.
9a. FACILITY NAME (If not institution, give street and number): MONTGOMERY GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: OLNEY		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: OLNEY		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 3353 MEGANS WAY		10f. ZIP CODE: 20832		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: KOREA	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): OPERATING ENGINEER		16b. KIND OF BUSINESS/INDUSTRY: BUREAU OF ENGRAVING
17. FATHER'S NAME (First, Middle, Last): EDDIE M. GODWIN, SR.			18. MOTHER'S NAME (First, Middle, Maiden Surname): JULIA PETRELLO	
19a. INFORMANT'S NAME (Type/Print): HELEN D. GODWIN WIFE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3353 MEGANS WAY OLNEY, MARYLAND 20832		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. MARY'S CEMETERY		20c. LOCATION — City or Town, State: WASHINGTON, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W. SIL.SPR.,MD. 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Prostate Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	Montgomery General Hospital ER OLNEY, MD OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Philip Schubert MD	MARYLAND D24398	▶ 12-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 15225 SHADY GROVE ROAD Suite 206 ROCKVILLE, MD 20850 Phone 330-0550

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 28 '89	Julia Davidson-Randall

DNMN-16 Rev 1/89

104

89 37449

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] should be obtained.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS JOE GRAHAM			2. DATE OF DEATH (Month, Day, Year): 12 28 89	3. TIME OF DEATH: 7:30 P M
4. SOCIAL SECURITY NUMBER: 242-60-2406	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6 Mar 1938	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Liberty Medical Center (ICU)		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Baltinore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2334 Pennsylvania Ave		10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 X Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Laborer	16b. KIND OF BUSINESS/INDUSTRY: Builders	
17. FATHER'S NAME (First, Middle, Last): Henry Graham		18. MOTNER'S NAME (First, Middle, Maiden Surname): Clara Edith	
19a. INFORMANT'S NAME (Type/Print): Cora Graham	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 1, Selma, N.C 27576		
20a. METHOD OF DISPOSITION: X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Selma Memorial Garden,	20c. LOCATION — City or Town, State: Johnston Co Selma, N.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] #799	22. NAME AND ADDRESS OF FACILITY: The House Of Williams F.S. 3821-14th St, N.W. Wash, D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease and Chronic Alcoholism

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO. Head only	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 X YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATN (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28g. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Julia C. Goodin, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 v1		
31. DATE FILED (Month, Day, Year): JAN 03 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMN-16 Rev 1/89

89 37450

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be retained at the funeral home for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be contacted at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHA GLANDEN		2. DATE OF DEATH (Month, Day, Year): December 6, 1989	3. TIME OF DEATH: 4:12PM M
4. SOCIAL SECURITY NUMBER: 213-14-1056	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): February 27, 1899 — 8. BIRTHPLACE (State or Foreign Country): Smyrna, DE
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge	9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: East New Market, Md.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Md. Rt. 16		10f. ZIP CODE: 21631	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): Raymond McBride		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Mae Clendaniel	
19a. INFORMANT'S NAME (Type/Print): Lee John Glanden		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 41 Denton, Md. 21629	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): East New Market	20c. LOCATION — City or Town, State: East New Market, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard O Zeller		22. NAME AND ADDRESS OF FACILITY: Zeller Funeral Home P.O. Box 207 East New Market, Md. 21631	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Respiratory Failure	one week
DUE TO (OR AS A CONSEQUENCE OF): a.	Respiratory Failure	one week
DUE TO (OR AS A CONSEQUENCE OF): b.	Sepsis from Wound Infection	3 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Sepsis from Wound Infection Malnutrition	3 weeks
DUE TO (OR AS A CONSEQUENCE OF): c.	malnutrition	chronic
DUE TO (OR AS A CONSEQUENCE OF): c.		Chronic
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Organic Brain Syndrome
Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ ND

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) — 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Joseph Zitarelli MD	29c. LICENSE NUMBER: D38627	29d. DATE SIGNED (Month, Day, Year): 12/6/89
30. NAME AND ADDRESS OF PERSON COMPLETING CAUSE OF DEATH (ITEM 27) (Type/Print): Joseph Zitarelli, MD. 4 Aurora St, Cambridge, Md. 21613	D38627 Aurora St, Cambridge, Md. 21613	12/6/89
31. DATE FILED (Month, Day, Year): 12/6/89 JAN - 4 '90	32. REGISTRAR'S SIGNATURE: Joseph Zitarelli MD Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37451

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last): CHARLES H. Gatton					2. DATE OF DEATH: MONTH 12 DAY 25 YEAR 89	3. TIME OF DEATH: 0658 AM
4. SOCIAL SECURITY NUMBER: 578-20-1725	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 04-08-22	8. BIRTHPLACE (State or Foreign Country): Washington D.C.
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville			9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Montgomery		10c. CITY, TOWN OR LOCATION: Germantown			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 13242 Meander Cove Drive			10f. ZIP CODE: 20874			10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WWII		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): technician			16b. KIND OF BUSINESS/INDUSTRY: telephone company
17. FATHER'S NAME (First, Middle, Last): Arthur Benjamin Gatton			18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Ethyl Wood			
19a. INFORMANT'S NAME (Type/Print): Mary A. Gatton			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13242 Meander Cove Drive Germantown MD 20874			
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery			20c. LOCATION — City or Town, State: Suitland MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Wilhelm			22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home, Inc. Suitland MD 20746			

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	12 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Ventricular Ectopy	2 month
	DUE TO (OR AS A CONSEQUENCE OF): c. Coronary Artery Disease	7 yrs
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Amoxic Encephalopathy

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: 24971	29d. DATE SIGNED (Month, Day, Year): ▶ 12/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dennis Trego MD 15225 Shady Grove Rd, Rockville md		
31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-18 Rev 1/89

89 37452

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marion Gene Harmon			2. DATE OF DEATH (Month, Day, Year): 12 28 89	3. TIME OF DEATH: 3:14A M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 51 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 10-15-38	8. BIRTHPLACE (State or Foreign Country): 51
9a. FACILITY NAME (If not institution, give street and number): 104 W. Martin St.	9b. CITY, TOWN OR LOCATION OF DEATH: Snow Hill	9c. COUNTY OF DEATH: Worcester		

RESIDENCE OF DECEDENT

10a. STATE: M.D.	10b. COUNTY: Worcester	10c. CITY, TOWN OR LOCATION: Snow Hill Maryland	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 104 West Martin St.	10f. ZIP CODE: 21863	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify: x	14. RACE — American Indian, Black, White, etc. Specify: Blk.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman — Retired	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): John M. Harmon	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel V. Harmon		
19a. INFORMANT'S NAME (Type/Print): Zenia M. Harmon	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2601 Jefferson St. Wilmington, Del. 19802		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Coolspring Ch. Cemetery	20c. LOCATION — City or Town, State: Girdletree Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell A. Fooks	22. NAME AND ADDRESS OF FACILITY: Fooks Funeral Home P.O.B 1574 Salisbury Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic alcohol abuse and fatty liver

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant	111 Penn St., Baltimore, MD 21201	
31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kimball	

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ONMN-18 Rev 1/89

89 37453

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDITH L. HURLOCK			2. DATE OF DEATH (Month, Day, Year): 12 - 30 - 89	3. TIME OF DEATH: 2:45A M
4. SOCIAL SECURITY NUMBER: 217-10-8433	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 4-9-11	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Anne Arundel Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Annapolis		9c. COUNTY OF DEATH: Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Hurlock		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 400 Railroad Avenue		10f. ZIP CODE: 21643		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress		16b. KIND OF BUSINESS/INDUSTRY: Clothing
17. FATHER'S NAME (First, Middle, Last): Herman C. Paul		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie K. Craft Paul		
19a. INFORMANT'S NAME (Type/Print): Richard Lee Hurlock		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 134, Hurlock, Maryland 21643		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Unity-Washington Cem		20c. LOCATION — City or Town, State: Hurlock, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Eskow		22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. cardiac arrest	hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): acute myocardial infarction	
	c. DUE TO (OR AS A CONSEQUENCE OF): coronary artery disease	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cardiogenic shock

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 5 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: G.A. Mitchell	29c. LICENSE NUMBER: D14758	29d. DATE SIGNED (Month, Day, Year) ▶ 1-4-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 205 Riggs Ave Annapolis MD 21401		
31. DATE FILED (Month, Day, Year): 1-10 JAN 16 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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(12)

89 37454

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Delores Harvey				2. DATE OF DEATH (Month, Day, Year): Dec 23 89			3. TIME OF DEATH: 12:15 M
4. SOCIAL SECURITY NUMBER: 470-16-9296	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 30 1920		8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): 6014 Naval Ave.			9b. CITY, TOWN OR LOCATION OF DEATH: Lanham Md			9c. COUNTY OF DEATH: Prince Georges	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Lanham	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6014 Naval Avenue		10f. ZIP CODE: 20706	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Cauc.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+): 1+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Data Entry	16b. KIND OF BUSINESS/INDUSTRY: ENCORE

17. FATHER'S NAME (First, Middle, Last): John Emmel	18. MOTHER'S NAME (First, Middle, Maiden Surname): Katherine Reiter
19a. INFORMANT'S NAME (Type/Print): Wayne C. Harvey	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6014 Naval Ave. Lanham, Maryland 20706

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery	20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard Rendon	22. NAME AND ADDRESS OF FACILITY: Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, MD 20706	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Dis.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Myocardial Dis.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] Rogers M.D.	29c. LICENSE NUMBER: D09975	29d. DATE SIGNED (Month, Day, Year): Dec 23, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours and completely filed in by the attending physician or retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been Signed by the attending physician and completely filed in by the hospital or attending physician, Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the State. Page 5 should be detached for use as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

89 37455

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Timothy Hawthorne Jr.		2. DATE OF DEATH (Month, Day, Year): Dec. 10, 1989	3. TIME OF DEATH: 5:30 A M
4. SOCIAL SECURITY NUMBER: 254-30-7170	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 26, 1925
8. BIRTHPLACE (State or Foreign Country): Georgia			
9a. FACILITY NAME (If not institution, give street and number): At Home	9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown	9c. COUNTY OF DEATH: Queen Anne's	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Queen Anne's	10c. CITY, TOWN OR LOCATION: Chestertown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: R.F.D.#1	10f. ZIP CODE: 21620	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Secondary; College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor	16b. KIND OF BUSINESS/INDUSTRY: Various	
17. FATHER'S NAME (First, Middle, Last): Timothy Hawthorne Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie Johnson		
19a. INFORMANT'S NAME (Type/Print): Miss. Ceresa Hawthorne	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 50 Riverdale Ave. Apt.#2F Yonkers New York 10171		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veteran Cem.	20c. LOCATION — City or Town, State: Hurlock	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth Walley	22. NAME AND ADDRESS OF FACILITY: WALLEY'S FUNERAL HOME 207 Calvert St. Chestertown, Md. 21620		

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ca of Oesophagus	1 yr
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): metastasis	
	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John R. Smith	29c. LICENSE NUMBER: D12345	29d. DATE SIGNED (Month, Day, Year): ▶ 12-19-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John R. Smith Jr. M.D. 110 Broadway St. Centreville, Maryland 21617

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37456

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be detached for the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEAN M. HUDGINS			2. DATE OF DEATH (Month, Day, Year): DEC. 28 1989	3. TIME OF DEATH: 7:40 A.M
4. SOCIAL SECURITY NUMBER: 578-34-9271	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): JUNE 26, 1930	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): 4712 WISSAHICAN AVENUE		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: ROCKVILLE		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 4712 WISSAHICAN AVENUE		10f. ZIP CODE: 20852		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANAGER		16b. KIND OF BUSINESS/INDUSTRY: N.I.H.	
17. FATHER'S NAME (First, Middle, Last): FREDERICK VERNON WILLIAMS, SR.			18. MOTHER'S NAME (First, Middle, Maiden Surname): ISSABELLE VIRGINIA TOWNSEND	
19a. INFORMANT'S NAME (Type/Print): JAMES A. HUDGINS (SON)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 813 BOWIE ROAD, ROCKVILLE, MARYLAND 20852		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY		20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael J Bigler		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	5 min
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Dis. / Myocardial Infarct	
	DUE TO (OR AS A CONSEQUENCE OF): c.	
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Howard Wolfstein MD | 29c. LICENSE NUMBER: D 20388 | 29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4701 Randolph Rd. Rockville, Md 20852

31. DATE FILED (Month, Day, Year): JAN 3 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

10

DHMH-18 Rev 1/89

89 37457

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE A. HARRY

2. DATE OF DEATH: MONTH Dec. DAY 27 YEAR 89

3. TIME OF DEATH: 8:30 M

4. SOCIAL SECURITY NUMBER: 216-02-4738

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): DECEMBER 18, 1937

8. BIRTHPLACE (State or Foreign Country): GUYANA

9a. FACILITY NAME (If not institution, give street and number): Wash Adventist Hosp.

9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: PRINCE GEORGES

10c. CITY, TOWN OR LOCATION: HYATTSVILLE

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER: 2102 LEWISDALE DRIVE

10f. ZIP CODE: 20783

10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ELECTRICIAN

16b. KIND OF BUSINESS/INDUSTRY: CONTRACTOR

17. FATHER'S NAME (First, Middle, Last): JOSEPH ALEXANDER SMITH

18. MOTHER'S NAME (First, Middle, Maiden Surname): DORCAS E. HARRY

19a. INFORMANT'S NAME (Type/Print): HEWLEY HARRY (SON)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 102-01 184th STREET, HOLLIS, NEW YORK 11423

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY

20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE

22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be retained by the funeral director for use as the burial-transit permit. Page 5 should be detached and retained by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infi.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: 009915

29d. DATE SIGNED (Month, Day, Year): Dec 28, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN S. ROGERS, M.D. 1919 SEMINARY ROAD SILVER SPRING, MARYLAND 20910

31. DATE FILED (Month, Day, Year): JAN 3 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMN-15 Rev 1/89

89 37458

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FLORENCE ELIZABETH HONSINGER			2. DATE OF DEATH (Month, Day, Year): DECEMBER 30, 1989	3. TIME OF DEATH: 6:10 AM
4. SOCIAL SECURITY NUMBER: 383-40-2318	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): APRIL 6, 1899	8. BIRTHPLACE (State or Foreign Country): MICHIGAN
9a. FACILITY NAME (If not institution, give street and number): 1416 MIMOSA LANE		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1416 MIMOSA LANE		10f. ZIP CODE: 20904		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER		16b. KIND OF BUSINESS/INDUSTRY: EDUCATION
17. FATHER'S NAME (First, Middle, Last): ANTHONY POMELLA		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH BADGERO		
19a. INFORMANT'S NAME (Type/Print): VERONICA J. KUEHNE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1416 MIMOSA LANE SILVER SPRING, MARYLAND 20904		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. LAWRENCE CEMETERY		20c. LOCATION — City or Town, State: UTICA, MICHIGAN
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael L. Bigler		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W. SIL.SPR.,MD. 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 must be completed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CEREBROVASCULAR ACCIDENT

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: HISTORY OF PRIOR CEREBROVASCULAR ACCIDENTS; ACUTE RENAL FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jonathan Plotsky MD	29c. LICENSE NUMBER: D38589	29d. DATE SIGNED (Month, Day, Year): ▶ JANUARY 2, 1990	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JONATHAN PLOTSKY MD 12102 GEORGIA AVENUE WHEATON, MARYLAND			
31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

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Items 10e&10f 1-24-90 FilmG659 W.H. Per F/H

89 37459 -

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages ... should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNEST JOSEPH HAMILTON			2. DATE OF DEATH (Month, Day, Year): 12-23-89	3. TIME OF DEATH: 3:22PM M
4. SOCIAL SECURITY NUMBER: 220-20-5034	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2/23/25	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. 1255 Peachleaf Court ~~1314 PENNSYLVANIA AVE.~~		10f. ZIP CODE: 21202		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER		16b. KIND OF BUSINESS/INDUSTRY: NA
17. FATHER'S NAME (First, Middle, Last): WILLIAM HAMILTON			18. MOTHER'S NAME (First, Middle, Maiden Surname): WINIFRED EPPS	
19a. INFORMANT'S NAME (Type/Print): EDITH MCCALIP		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1230 PEACHLEAF COURT/BALTIMORE, MD 21202		
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) [illegible]		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARRSION FOREST VET CEM		20c. LOCATION — City or Town, State: OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: WM. C. MARCH F/H 1101 E. NORTH AVENUE		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Tamponade

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Ruptured myocardial infarct

DUE TO (OR AS A CONSEQUENCE OF):

c. Arteriosclerotic cardiovascular disease

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXXX YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: XXX 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 XXX Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XXX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: OCME

29d. DATE SIGNED (Month, Day, Year): ▶ 12-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,MD 111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year): JAN 22 1990

32. REGISTRAR'S SIGNATURE: [signature]

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page[illegible] the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral d[illegible] the detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DANIEL KENNETH HAAN				2. DATE OF DEATH: MONTH DEC. DAY 30, YEAR 1989	3. TIME OF DEATH: 12:22 A M
4. SOCIAL SECURITY NUMBER: 220-26-9929	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAR. 10, 1931	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SACRED HEART HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CUMBERLAND		9c. COUNTY OF DEATH: ALLEGANY

RESIDENCE OF DECEDENT

10a. STATE: WEST VA.	10b. COUNTY: MINERAL	10c. CITY, TOWN OR LOCATION: RIDGELEY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: ROUTE 2, BOX 95		10f. ZIP CODE: 26753	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: Korean Conflict	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self-employed	15b. KIND OF BUSINESS/INDUSTRY: Auto Sales

17. FATHER'S NAME (First, Middle, Last): DANIEL HAAN	18. MOTHER'S NAME (First, Middle, Maiden Surname): ELSIE E. LEASE
19a. INFORMANT'S NAME (Type/Print): KATHLEEN HAAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): ROUTE 2, BOX 95-RIDGELEY, WV 26753

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HILLCREST BURIAL PARK	20c. LOCATION — City or Town, State: CUMBERLAND, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hardy M. Upchurch	22. NAME AND ADDRESS OF FACILITY: GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart failure. Liet only one ceuse on eech line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPHYXIA	2-3 minutes
DUE TO (OR AS A CONSEQUENCE OF):	Massive aspiration gastric content	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Giovanni Mastrangelo DEPUTY MED	29c. LICENSE NUMBER: D07098	29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GIOVANNI MASTRANGELO, M.D., Dep.Med.Ex.-900 Seton Drive, Cumberland, MD 21502			
31. DATE FILED (Month, Day, Year): JAN 03 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES M. HAYNES (James Milton Haynes)				2. DATE OF DEATH: MONTH 12, DAY 31, YEAR 89	3. TIME OF DEATH: 920 AM (military)
4. SOCIAL SECURITY NUMBER: 402 26 4392	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 8, 1925	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): 3025 Greenway Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Ellicott City		9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 3025 Greenway Drive		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Power Bureau	16b. KIND OF BUSINESS/INDUSTRY: B& O Railroad	
17. FATHER'S NAME (First, Middle, Last): David Haynes		18. MOTHER'S NAME (First, Middle, Maiden Surname): Zora Lovell	
19a. INFORMANT'S NAME (Type/Print): ~~Mrs Ida Haynes~~ Mrs. Dorothy Haynes		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 206 Worthmont Rd. Catonsville, MD 21228	
20a. METHOD OF DISPOSITION: X 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ~~Meadowridge~~ MD Veterans	20c. LOCATION — City or Town, State: Garrison Forest Balto.MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke		22. NAME AND ADDRESS OF FACILITY: Harry H Witzke Funeral HOme Inc 4112 OLd Columbia Pike Ellicott City	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. HISTORY OF ANGINA PECTORIS (ACCORDING TO FAMILY)	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ✓ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ✓ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert S Goodwin, MD	29c. LICENSE NUMBER: D23081	29d. DATE SIGNED (Month, Day, Year): ▶ 12-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT S GOODWIN, M.D. 9650 SANTIAGO ROAD COLUMBIA, MD. 21045

31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELIZABETH M. HALL				2. DATE OF DEATH (Month, Day, Year): Dec 21 1989	3. TIME OF DEATH: 4:40 A M
4. SOCIAL SECURITY NUMBER: 577-10-2139	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov 11, 1902	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Columbia	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9413 Sunfall Ct.		10f. ZIP CODE: 21046	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 2		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): New Accounts Officer	16b. KIND OF BUSINESS/INDUSTRY: Banking
17. FATHER'S NAME (First, Middle, Last): Horatio Moran		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Poole	
19a. INFORMANT'S NAME (Type/Print): Suzanne O'Connell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9413 Sunfall Ct., Columbia, MD 21046	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons 5130 WIsconsin Av., Washington, DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Anemia due to gastrointestinal bleeding, site never discovered.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 9 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: BK Lane, M.D.	29c. LICENSE NUMBER: D 27733	29d. DATE SIGNED (Month, Day, Year): ▶ 12/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 14201 Laurel Park Dr. #223, Laurel, MD 20707		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-18 Rev 1/89

15

89 37463

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Raymond T. Haines		2. DATE OF DEATH (Month, Day, Year): December 20,1989	3. TIME OF DEATH: 4:30 p M
4. SOCIAL SECURITY NUMBER: 419-09-0710	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 18,1912	8. BIRTHPLACE (State or Foreign Country): Alabama		
9a. FACILITY NAME (If not institution, give street and number): 11505 Joseph Mill Road	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 11505 Joseph Mill Road	10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 XX YES 2 ☐ NO IF YES, GIVE WAR OR DATES: WW 11	13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales	16b. KIND OF BUSINESS/INDUSTRY: Drug Store	
17. FATHER'S NAME (First, Middle, Last): Raymond Thomas Haines	18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa McShan		
19a. INFORMANT'S NAME (Type/Print): Frances Haines	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11505 Joseph Mill Road Silver Spring, Maryland		
20a. METHOD OF DISPOSITION: 1 XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park	20c. LOCATION — City or Town, State: Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Bruce T. Kephart M00335	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/ Rockville Inc. 300 West Montgomery Avenue Rockville, Maryland 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	Probably less than 5 minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Heart Disease - had myocardial infarction	7yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus -

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Aaron H. Traum MD	29c. LICENSE NUMBER: D-12461	29d. DATE SIGNED (Month, Day, Year): December 22,1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Aaron H. Traum M.D. 8915 Georgia Avenue Silver Spring, Maryland 20910

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37464

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last): William H. Hannah					2. DATE OF DEATH (Month, Day, Year): December 24, 1989	3. TIME OF DEATH: 9:17 A M
4. SOCIAL SECURITY NUMBER: 152 14 0745	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 16, 1906	8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT						
10a. STATE: New Jersey	10b. COUNTY: Middlesex		10c. CITY, TOWN OR LOCATION: South Plainfield		10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO	
10e. STREET AND NUMBER: 1382 Schindler Drive			10f. ZIP CODE: 07080		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): -			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Selector		16b. KIND OF BUSINESS/INDUSTRY: Grocery Store Warehouse	
17. FATHER'S NAME (First, Middle, Last): Ernest W. Hannah			18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara M. Ferris			
19a. INFORMANT'S NAME (Type/Print): Clarice M. Taboada			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 804 Madison Street Rockville, Maryland 20850			
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Restland Memorial Park		20c. LOCATION — City or Town, State: East Hanover, New Jersey	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] M00689			22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Aspiration Pneumonia	18 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. (L) Cerebrovascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 X NO	HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Phyllis Schreiner M.D.	D26520	▶ 12-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Phyllis Schreiner MD 50 W Edmonston Dr Rockville, Md 20852

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	Julia Davidson Randall

DHMH-16 Rev 1/89

12

89 37465

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry W. Howard		2. DATE OF DEATH (Month, Day, Year): December 20, 1989	3. TIME OF DEATH: 11:00 AM
4. SOCIAL SECURITY NUMBER: 332 09 5159	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 19, 1899
8. BIRTHPLACE (State or Foreign Country): Illinois			
9a. FACILITY NAME (If not institution, give street and number): Friends Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Sandy Spring	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 14401 Pecan Drive	10f. ZIP CODE: 20853	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister	16b. KIND OF BUSINESS/INDUSTRY: Church	
17. FATHER'S NAME (First, Middle, Last): Harry Sampson Howard	18. MOTHER'S NAME (First, Middle, Maiden Surname): Tillie Kiesel		
19a. INFORMANT'S NAME (Type/Print): Mary Elizabeth Howard Low	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14401 Pecan Drive Rockville, Maryland 20853		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Norbeck Memorial Park	20c. LOCATION — City or Town, State: Olney, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] M00689	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	5 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. gangreen left leg	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
	c. Stroke	1 month
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dennis M. Hannon MD	29c. LICENSE NUMBER: D23124	29d. DATE SIGNED (Month, Day, Year): ▶ 12.20.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dennis M. Hannon, MD 18117 Prince Philip Olney, MD 20832

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

10

DHMH-16 Rev 1/89

89 3745

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Leola M. Harris
2. DATE OF DEATH (Month, Day, Year): 12-23-1989
3. TIME OF DEATH: 520 M
4. SOCIAL SECURITY NUMBER: 577-48-0265
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 98 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/19/1891
8. BIRTHPLACE (State or Foreign Country): KENTUCKY
9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME
9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE
9c. COUNTY OF DEATH: MONTGOMERY CO.

RESIDENCE OF DECEDENT

10a. STATE: DC
10b. COUNTY: NONE
10c. CITY, TOWN OR LOCATION: WASHINGTON
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5402- CONNECTICUT AVENUE, N.W.
10f. ZIP CODE: 20015
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY
16b. KIND OF BUSINESS/INDUSTRY: NOT AVAILABLE
17. FATHER'S NAME (First, Middle, Last): AMOS C. EWING
16. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ANN HUME
19a. INFORMANT'S NAME (Type/Print): REV.DR. REICHARD
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701-VEIRS DR.,ROCKVILLE,MD. 20850
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN MAUSOLEUM
20c. LOCATION — City or Town, State: BRENTWOOD,MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William M. Hysong
22. NAME AND ADDRESS OF FACILITY: HYSONG CO.,INC. 1300- N STREET,N.W. WASH.,DC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute CVA	Acute
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO XX
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas E. Dooley, M.D.
29c. LICENSE NUMBER: D16458
29d. DATE SIGNED (Month, Day, Year): ▶ Dec 23, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas E. Dooley, M.D., 17904 Georgia Avenue, Olney MD 20832
31. DATE FILED (Month, Day, Year): JAN 8 '90
32. REGISTRAR'S SIGNATURE: Sylvia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Marie Hebron — HELEN MARIE HEBRON
2. DATE OF DEATH: MONTH 12-30-89 YEAR — 12 30 89
3. TIME OF DEATH: 1733 M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☐ F
6. AGE (In yrs. last birthday): 63 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-10-26
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hosp. — SHADY GROVE ADV HOSP
9b. CITY, TOWN OR LOCATION OF DEATH: Rockville
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Germantown
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 20134 Club Hill Drive
10f. ZIP CODE: 20874
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Arthur P. Naylor
18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Bowie
19a. INFORMANT'S NAME (Type/Print): Robert Hebron (son)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20134 Club Hill Dr., Germantown, MD 20874
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul A.M.E. Cemetery
20c. LOCATION — City or Town, State: Della, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: George R. Snowden
22. NAME AND ADDRESS OF FACILITY: Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md

TO BE COMPLETED BY PHYSICIAN OR MEDICAL CERTIFICATION

23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gastro-Intestinal Bleeding — Gastrointestinal Bleeding — Approximate Interval Between Onset and Death: 1 day.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Renal Failure, Hypertensive Heart Disease (Chronic Renal Failure, Hypertension, Heart Disease. Hyper

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Barry Hecht, M.D.
29c. LICENSE NUMBER: D14192
29d. DATE SIGNED (Month, Day, Year): ▶ December 31, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARRY HECHT, MD 3941 FERRARA DRIVE WHEATON, MD 20906
31. DATE FILED (Month, Day, Year): JAN 5 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37468

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth E. Houk			2. DATE OF DEATH (Month - Day - Year): 12 - 26 - 89	3. TIME OF DEATH: 6:40 AM
4. SOCIAL SECURITY NUMBER: 245-03-3895	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): July 14, 1905	8. BIRTHPLACE (State or Foreign Country): Boston, MA
8a. FACILITY NAME (If not institution, give street and number): Summit Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Columbia	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9934 Ferndale Avenue		10f. ZIP CODE: 21046	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Communications	
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): Wade B. Houk, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9934 Ferndale Avenue Columbia, MD 21046	

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Baltimore Washington Crematory	20c. LOCATION — City or Town, State: Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring RD Laurel, MD 20707	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute pneumonitis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ASCVD
Cerebral ischemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James E Rowe M D	29c. LICENSE NUMBER: D 13170	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. E. Rowe Summit Nursing Home

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-15 Rev 1/89

89 37469

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRINGTON Jesse W
2. DATE OF DEATH (Month, Day, Year): 12 30 89
3. TIME OF DEATH: 2330 PM
4. SOCIAL SECURITY NUMBER: 221-07-8062
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 3/19/1898
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Union Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Elkton
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Elkton
10d. INSIDE CITY LIMITS? 1 [XX] YES 2 [ ] NO
10e. STREET AND NUMBER: 2207 Barksdale Rd.
10f. ZIP CODE: 21921
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 years; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter
16b. KIND OF BUSINESS/INDUSTRY: University
17. FATHER'S NAME (First, Middle, Last): William H. Harrington
18. MOTHER'S NAME (First, Middle, Maiden Surname): Hester Sophia Janney
19a. INFORMANT'S NAME (Type/Print): W. Jay Harrington
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 713 Swathmore Dr., Newark, DE. 19711
20a. METHOD OF DISPOSITION: 1 [XX] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): West Nottingham Cemetery
20c. LOCATION — City or Town, State: Colora, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank C Mayer Jr. / Frank C. Mayer, Jr.
22. NAME AND ADDRESS OF FACILITY: Spicer-Mullikin Funeral Homes, Inc. 121 W. Park Pl., Newark, DE. 19711

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sepsis - t wd	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Acute Cholangitis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atrial Fibrillation with Rapid Vent. Response	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [XX] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: T. Ty O'Donnell MD
29c. LICENSE NUMBER: D33510
29d. DATE SIGNED (Month, Day, Year): 12-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Timothy O'Donnell, M.D Union Hospital Cecil County Elkton, MD
31. DATE FILED (Month, Day, Year): JAN 08 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

10

ITEM:4 per FH G-659
1-30-90 cm #7

89 37470

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH Month / Day / Year	3. TIME OF DEATH
MICHAEL	JAMES	HARDESTY, SR.	12 / 15 / 89	1:00 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
~~219-09-6619~~ 217-94-6619	1 [X] M 2 [ ] F	22 YRS.			Dec. ~~15~~ 14, 1967	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2823 Crain Highway	Upper Marlboro	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Md.	Prince George's	Riverdale	[X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
6005 Madison Street	20737	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
(11)	None	Heavy Equipment Operator	Construction Company

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Ralph Wilbur Hardesty, Sr.	Ida Marie Mayhew

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Michelle Hardesty	6005 Madison St., Riverdale, Md. 20737

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Trinity Memorial Gardens	Waldorf, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Richard A. Coleman	Richard A. Coleman Funeral Home Upper Marlboro, Maryland 20772

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hanging	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
[X] YES 2 [ ] NO	[X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA — OTHER: 4 Nursing Home 5 Residence 6 [X] Other (Specify) scene
[X] YES 2 [ ] NO	

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	12-14-89	M	1 [ ] YES 2 [X] NO	Subject hanged self

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
barn	2823 Crain Highway, Upper Marlboro, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ann M. Dixon, M.D.	OCME	▶ 12-16-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
Ann M. Dixon, M.D.	111 Penn Street	Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 09 '90	Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

89 37471

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jeannette C. Jones				2. DATE OF DEATH (Month, Day, Year): 12-5-1989	3. TIME OF DEATH: 1:02 P M
4. SOCIAL SECURITY NUMBER: 029-20-3664	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 8, 1910	8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center			9b. CITY, TOWN OR LOCATION OF DEATH: Centreville		9c. COUNTY OF DEATH: Queen Anne's
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Queen Anne's	10c. CITY, TOWN OR LOCATION: Centreville			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 308 N. Commerce Street		10f. ZIP CODE: 21620			10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): College	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher		16b. KIND OF BUSINESS/INDUSTRY: Ed.	
17. FATHER'S NAME (First, Middle, Last): James H. Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy B. Carlos Jones			
19a. INFORMANT'S NAME (Type/Print): Mr. Shelton J. Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 308 N. Commerce St. Centreville, Md. 21620			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chesterfield Cemetery		20c. LOCATION — City or Town, State: Centreville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: WALLEY'S FUNERAL HOME 207 Calvert St. Chestertown, Md. 21620			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. A.S.C.V.D.	5 yrs +
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John R Smith Jr	D12345	▶ 12-7-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.R. Smith Jr Court House Square Centreville, Md 21617

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 19 '89	Julia Davidson-Randall

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OHMH-16 Rev 1/89

89 37472

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Matilda J Johnson			2. DATE OF DEATH (Month, Day, Year): December 11, 1989	3. TIME OF DEATH: 8:25 A.M.
4. SOCIAL SECURITY NUMBER: 213-26-3575	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 9, 1914	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Queen Anne's	10c. CITY, TOWN OR LOCATION: Centreville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 104 Jones Street		10f. ZIP CODE: 21617	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): College	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing	16b. KIND OF BUSINESS/INDUSTRY: Nurse

17. FATHER'S NAME (First, Middle, Last): Charles Brooks Sr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie Munday
19a. INFORMANT'S NAME (Type/Print): Mr. Kenneth Kennedy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 323 Calvert St. Chestertown, Maryland 21620

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Zion U.M. Cemetery	20c. LOCATION — City or Town, State: R.F.D. Centreville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kenneth Walley	22. NAME AND ADDRESS OF FACILITY: WALLEY'S FUNERAL HOME 207 Calvert St. Chestertown, Md. 21620	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	bowel obstruction & sepsis	2 wks
OUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	adhesions	4 wks
OUE TO (OR AS A CONSEQUENCE OF):		
c.	sigmoid volvulus	6 wks
OUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles E. DiNapoli M.D.	29c. LICENSE NUMBER: D38990	29d. DATE SIGNED (Month, Day, Year): ▶ 12-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles E. DiNapoli MD 404 MARVEL Court EASTON MD 21601

31. DATE FILED (Month, Day, Year): DEC 19 '89	32. REGISTRAR'S SIGNATURE: Jicka Davidson-Randall

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OHMH-18 Rev 1/89

89 37473

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HERBERT ARVID JOHNSON			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH: 1815 M
4. SOCIAL SECURITY NUMBER: 330-09-9698	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 6 18	8. BIRTHPLACE (State or Foreign Country): Illinois
9a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore, Md.		9c. COUNTY OF DEATH:
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Brookville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4385 Old Roxbury Rd.		10f. ZIP CODE: 20833		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Johns Hopkins Appl.Physics	16b. KIND OF BUSINESS/INDUSTRY: Lab.	
17. FATHER'S NAME (First, Middle, Last): Arvid Johnson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Svensson		
19a. INFORMANT'S NAME (Type/Print): Eleanor Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4385 Old Roxbury Rd. Brookeville, Md. 20833		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	20c. LOCATION — City or Town, State: Catonsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke		22. NAME AND ADDRESS OF FACILITY: HARRY H. WITZKE FUNERAL HOME 4112 Columbia Rd., Ellicott City, Md. 21043		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC LUNG CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]		▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAM BALAGTAS MD 900 CATON AVE BALTIMORE MD 21228

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 '90	[signature]

DHMH-16 Rev 1/89

15

89 37474

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Irvin S. Jenkins
2. DATE OF DEATH (Month, Day, Year): 12 / 28 / 89
3. TIME OF DEATH: 1915 M
4. SOCIAL SECURITY NUMBER: 214-12-7554
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/13/14
8. BIRTHPLACE (State or Foreign Country): Illinois
8a. FACILITY NAME (If not institution, give street and number): St. Agnes Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 532 Sunset Road
10f. ZIP CODE: 21223
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk
16b. KIND OF BUSINESS/INDUSTRY: Md. Workshop for the blind
17. FATHER'S NAME (First, Middle, Last): Noah Jenkins
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha A. Fincham
19a. INFORMANT'S NAME (Type/Print): Deloris Maxine Jenkins
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 532 Sunset Rd., Balto., Md. 21223
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Emmanuel Cemetery
20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Gary L. Kaufman Funeral Homes, 5695 Main Street, Elkridge, Md. 21227

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAUL BALAGTAS MD 900 CATON AVE BALTIMORE MD 21229
31. DATE FILED (Month, Day, Year): JAN 2 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37475

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAULINE B. JONES			2. DATE OF DEATH (Month, Day, Year): DECEMBER 28, 1989	3. TIME OF DEATH: 1725 M
4. SOCIAL SECURITY NUMBER: 216-18-8278	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-13-1921	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: CHANCE Md.		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P.O. Box 96		10f. ZIP CODE: 21816		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: Black		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 6+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer		16b. KIND OF BUSINESS/INDUSTRY: Housewife
17. FATHER'S NAME (First, Middle, Last): John Beckett		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Collins		
19a. INFORMANT'S NAME (Type/Print): Arthur Jones Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 96 Chance Md 21816		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St Charles Cem.		20c. LOCATION — City or Town, State: Chance Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kathy E. Ward		22. NAME AND ADDRESS OF FACILITY: 103 Hampden Ave Princess Anne Md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Renal failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Congestive Heart failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Pneumonia.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ignatius T. DiNardo M.D.	D 31546	▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Ignatius L. DiNardo M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37476

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET B. JACKSON
2. DATE OF DEATH (Month, Day, Year): 12 25 89
3. TIME OF DEATH: 7 00 PM
4. SOCIAL SECURITY NUMBER: 579-18-8480
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 86 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4-11-03
8. BIRTHPLACE (State or Foreign Country): Lynchburg VA
9a. FACILITY NAME (If not institution, give street and number): Hyattsville Manor
9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville MD
9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Washington D.C.
10b. COUNTY: —
10c. CITY, TOWN OR LOCATION: Washington, D.C.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3918-13th Street N.W.
10f. ZIP CODE: 20011
10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY: Government

17. FATHER'S NAME (First, Middle, Last): Elias Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillie B. Jackson

19a. INFORMANT'S NAME (Type/Print): Rosa V. Taylor
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3918 13th Street, NW., Washington, D. C. 20011

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. P. Marshall
22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home, 4217 9th Street, N. W., Washington, D. C. 20011

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest — immed

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. arteriosclerotic heart disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Walter E. Goozh MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 12-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Walter E. Goozh 2309 Shorefield Road Wheaton, Md. 20902

31. DATE FILED (Month, Day, Year): JAN 03 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37477

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 must be completed by the attending physician or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JEANNETTE KARPMAN				2. DATE OF DEATH (Month, Day, Year): 12 - 31 - 1989	3. TIME OF DEATH: 6:55A M
4. SOCIAL SECURITY NUMBER: 063-03-6024	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5/1/02	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Hebrew Home of Greater Washington			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville			10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 6121 Montrose Road		10f. ZIP CODE: 20852		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES X	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary (Retired)	16b. KIND OF BUSINESS/INDUSTRY: U.S.Gov't.			
17. FATHER'S NAME (First, Middle, Last): David Metzik		18. MOTHER'S NAME (First, Middle, Maiden Surname): Etta Klein			
19a. INFORMANT'S NAME (Type/Print): Dorothy Rosenberg (Niece)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1209 Devere Drive; Silver Spring, Md. 20903				
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Suburban Crematory	20c. LOCATION — City or Town, State: Silver Spring, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frank A. Stone	22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 Rockville Pike; Rockville, Md. 20852				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PROBABLE MYOCARDIAL INFARCTION	15min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASHD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEMENTIA
CHF
DIABETES MELLITUS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Merlyn Vemury MD Attending Physician

29c. LICENSE NUMBER: D35791

29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MERLYN VEMURY, MD HEBREW HOME OF GREATER WASHINGTON

31. DATE FILED (Month, Day, Year): JAN 3 '90

32. REGISTRAR'S SIGNATURE: Gisha Davidson-Rondeau

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DHMH-16 Rev 1/89

89 37478

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the ... physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached ... transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: It item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) JACK R. KERGE JACK R. KERGE			2. DATE OF DEATH MONTH 12 DAY 31 YR 89	3. TIME OF DEATH 1510 3:10P M
4. SOCIAL SECURITY NUMBER 578-48-2103	5. SEX XX M 2 ☐ F	6. AGE (In yrs. last birthday) 51 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG. 12, 1938
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				
9a. FACILITY NAME (If not institution, give street and number) 1039 TURKEY POINT RD.	9b. CITY, TOWN OR LOCATION OF DEATH EDGEWATER	9c. COUNTY OF DEATH ANNE ARUNDEL		

RESIDENCE OF DECEDENT

10a. STATE MD.	10b. COUNTY ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION EDGEWATER	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER 1039 TURKEY POINT RD.	10f. ZIP CODE 21037	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	

11. MARITAL STATUS 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES MID 60'S	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

16. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 / College (1-4 or 5+)	18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) GENERAL SALES MANAGER	18b. KIND OF BUSINESS/INDUSTRY LUSTINE CHEVROLET	

17. FATHER'S NAME (First, Middle, Last) ZACK KERGE	18. MOTHER'S NAME (First, Middle, Maiden Surname) JULIA KARUTA
19a. INFORMANT'S NAME (Type/Print) JAN E. KERGE	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10

20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) LAKEMONT MEMORIAL GARDENS	20c. LOCATION — City or Town, State DAVIDSONVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ W W Chambers MO0091	22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardisc or respiratory srreat, shock, or haart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE Respiratory failure

DUE TO (OR AS A CONSEQUENCE OF): LUNG CANCER Lung Concer

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): COPD

c. DUE TO (OR AS A CONSEQUENCE OF): COPD

d. DUE TO (OR AS A CONSEQUENCE OF):

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Michael Jr Adentz MD	29c. LICENSE NUMBER D 21438	29d. DATE SIGNED (Month, Day, Year) ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 703 GIDDINGS AVE, SUITE M1 DR. MICHAEL J. ADENTZ ANNAPOLIS, MD 21401		
31. DATE FILED (Month, Day, Year) JAN 4 '90	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

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DHMH-18 Rev 1/89

89 37479

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
THEODORE KANE		12 / 28 / 89	11:44 AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-10-0411	XX M 2 ☐ F	77 YRS.			1-29-1912	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Perry Point Veterans Center	Perryville, MD	Cecil

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Dorchester	Cambridge, Maryland	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
630 Washington St.	21613	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 9-43 to 11-45	1 ☐ YES 2 ☐ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	Laborer	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Dorsey Kane	Alice Kane

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mae Kane	630 Washington St. Cambridge, Md.

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Maryland Veteran Cemetery	Hurlock, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Bennie L. Smith	Bennie Smith Services PO Box 925 Hurlock, Md. 21643

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kam-Ken Leung MD	D16606MD	▶ Dec. 29 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Kam-Ken Leung, M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN - 9 '90	Julia Davidson-Parker

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours. A copy may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, see page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from State.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

89 37480

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be filed within 72 hours after death with the local registrar and burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KRIKOR P. KALAYDJIAN				2. DATE OF DEATH (Month, Day, Year): 12 29 89	3. TIME OF DEATH: 2:30 A M
4. SOCIAL SECURITY NUMBER: 217-70-3149	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MAY 28, 1912	8. BIRTHPLACE (State or Foreign Country): TURKEY
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 12637 GEORGIA AVENUE #204		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY?: LEBANON

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COBBLER	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): PENJAMIN KALAYDJIAN		18. MOTHER'S NAME (First, Middle, Maiden Surname): MERIAM MEKHDJIAN	
19a. INFORMANT'S NAME (Type/Print): HOWARD A. CORSON,JR.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4421 RANDOM COURT ANNANDALE, VIRGINIA 22003		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY	20c. LOCATION — City or Town, State: SILVER SPRING,MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD.,W. SIL.SPR.,MD. 20901		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Bronchopneumonia	1 Month
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. arteriosclerotic vascular disease	1 year
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	DO 1120	29 Dec 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WALTER E. GOOZH MD 2309 SHORELIFIELD ROAD WHEATON MD 20902

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	[signature]

4

DHMH-16 Rev 1/89

89 37481

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
Howard	King	12 / 21 / 89	1:55 AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-22-1989	1 [X] M 2 [ ] F	92 YRS.			02/25/97	Raleigh NC

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Grosvenor Health Care Center	Bethesda	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Montgomery	Bethesda	1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
5721 Grosvenor Lane	20814	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th		Bank Messenger	None

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
James King	Mary (unknown)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Doris Mackell	84 Allison St., N.E., Washington, D.C. 20011

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Lincoln Memorial Park	Suitland, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James E Vann F.H. Inc President #702	4804 Baltimore Ave, Washington D.C. 20011

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular Accident	1988
DUE TO (OR AS A CONSEQUENCE OF):	b. CAD	1988
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. COPD	1988
DUE TO (OR AS A CONSEQUENCE OF):	d. ASCVD	1988

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

Gastrostomy Tube feeding

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	N/A	M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
GBPatrick III MD	D17729	▶ 12/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
G B Patrick III MD 9201 Colesville Rd SS, Md 20910

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Julia Davidson-Randall

(3)

DHMH-16 Rev 1/89

89 37482

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page ... a hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral dir... detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must... once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chester Martin Kaminskie / Chester M. Kaminskie			2. DATE OF DEATH: MONTH Dec DAY 24 YEAR 89	3. TIME OF DEATH: 2330 M
4. SOCIAL SECURITY NUMBER: 186-26-6475	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 52 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 2-2-37	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel/Beltsville Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George's		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Laurel		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9175 A Hitching Post Lane		10f. ZIP CODE: 20707		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Korean War	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Technical Writer	16b. KIND OF BUSINESS/INDUSTRY: Litton Amecon		
17. FATHER'S NAME (First, Middle, Last): Albert Kaminskie		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rose Sienkiewicz		
19a. INFORMANT'S NAME (Type/Print): Jean Kaminskie	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9175 A Hitching Post Lane Laurel, MD 20707			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): All Saints Cemetery	20c. LOCATION — City or Town, State: Elysburg, PA		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Fleck Funeral Home, Inc. 7601 Sandy Spring Rd. Laurel, MD 20707			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Dis.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: D09975	29d. DATE SIGNED (Month, Day, Year): Dec 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

(10)

89 37483

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
JEAN	KLAVAN	DEC. 24, 1989	8:45 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577-56-1151	1 ☐ M 2 XX F	85 YRS.			DEC 25, 1903	RUSSIA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Potomac Valley Nursing Home	Rockville	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	MONTGOMERY	BETHESDA	XX 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
10250 WESTLAKE DR #511	20817	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married XX 3 ☒ Widowed 4 ☐ Divorced	XX 1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO XX Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		HOMEMAKER	HOME

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
MORRIS SCHWARTZ	MOLLIE (UNK)

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JUDGE STANLEY KLAVAN	11508 YATES ST. SILVER SPRING, MD 20902

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	OHEV SHOLOM TALMUD TORAH	WASHINGTON D.C.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Gary M. Gruber	Danzansky-Goldberg Memorial Chapels 1170 Rockville Pike, Rockville, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBRODASCULAR ACCIDENT	mnths
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO XX	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	25. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 5 ☐ Pending investigation 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be determined 4 ☐ Homicide		— M	1 ☐ YES 2 ☐ NO	—
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
	—		—	

29a. CERTIFIER (Check only one)
XX 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Eric Tannenbaum, MD	RT0171328	▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Eric S. Tannenbaum, M.D. 2150 PENN AVE. NW. WASHINGTON D.C. 20037

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	[illegible]

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the Funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

4

89 37484

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate should be signed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Annette Knoch					2. DATE OF DEATH (Month / Day / Year): 12 / 29 / 89	3. TIME OF DEATH: 6:55 p M	
4. SOCIAL SECURITY NUMBER: 577-20-2409	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9/15/1905	8. BIRTHPLACE (State or Foreign Country): Russia	
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Olney		9c. COUNTY OF DEATH: Montgomery		
RESIDENCE OF DECEDENT							
10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: S. WHEATON SPRNG			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO		
10e. STREET AND NUMBER: 14508 Homecrest Rd		10f. ZIP CODE: 20906			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker			16b. KIND OF BUSINESS/INDUSTRY: Home		
17. FATHER'S NAME (First, Middle, Last): Sam Kahansky					18. MOTHER'S NAME (First, Middle, Maiden Surname): Frumitcipi (Unknown)		
19a. INFORMANT'S NAME (Type/Print): Max Knoch (son)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12803 Sholton St., Largo, MD 20782		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Lebanon Cemetery		20c. LOCATION — City or Town, State: Adelphi, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Gary M. Gise			22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE, ROCKVILLE, MD				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Cardiovascular Disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Paul DeVore MD Deputy medical Examiner	D01852	▶ 12/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul A. DeVore, MD, 4203 Queensbury Rd., Hyattsville, MD 20781

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	Lidia Davidson-Randall

DHMH-18 Rev 1/89

89 37485

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Raymond J. Kolb			2. DATE OF DEATH (Month, Day, Year): Dec. 29, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 218-18-4581	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/10/05	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1106 Meadowlark Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Halethorpe		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Wynnewood	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1106 Meadowlark Drive		10f. ZIP CODE: 21227	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: n/a	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: no	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): auditor	16b. KIND OF BUSINESS/INDUSTRY: gov't
17. FATHER'S NAME (First, Middle, Last): Nicholas Kolb		18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Von Thalhimer
19a. INFORMANT'S NAME (Type/Print): Catherine M. Kolb	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1106 Meadowlark DriveHalethorpe Md 21227	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Dorsey, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: AMBROSE FUNERAL HOME 1328 SULPHUR SPRING ROAD, ARBUTUS, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Carcinoma Lung Metastatic — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Pleural effusion — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO		28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D25044	29d. DATE SIGNED (Month, Day, Year): ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): M. REHMAN 2717 HAMMONDS FERRY Rd 21227		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

15

89 37486

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jacobo Kranz				2. DATE OF DEATH (Month, Day, Year): Dec 30 1989		3. TIME OF DEATH: 12 30 PM
4. SOCIAL SECURITY NUMBER: 578 72 5649	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): June 23, 1907	8. BIRTHPLACE (State or Foreign Country): Austria
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring			9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 902 Nora Drive		10f. ZIP CODE: 20904	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sexton	16b. KIND OF BUSINESS/INDUSTRY: Synagogue	
17. FATHER'S NAME (First, Middle, Last): Leib Kranz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pinie Witkowski	
19a. INFORMANT'S NAME (Type/Print): Jose Kranz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 18608 Herritage Drive, Brookville, Maryland 20833	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Lebanon Cemetery	20c. LOCATION — City or Town, State: Adelphi, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein		22. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial Infarction	Minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Cardiovascular Disease	Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Old Tuberculosis infection	Years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Marvin Schneider M.D	D11428	▶ 12/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARVIN SCHNEIDER M.D. 12001 FERRARA AVE; WHEATON MD 20906

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 10 1990	Julia Dawson-Mitchell

DHMH-16 Rev 1/89

89 37487

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gloria A. Kao

2. DATE OF DEATH — MONTH: 12 DAY: 22 YEAR: 89

3. TIME OF DEATH: 9 20 P M

4. SOCIAL SECURITY NUMBER: 579-76-6243

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 54 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Nov. 23, 1935

8. BIRTHPLACE (State or Foreign Country): China

9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Rockville

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 12601 Celtic Court

10f. ZIP CODE: 20850

10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12 — College (1-4 or 5+): –

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): President

16b. KIND OF BUSINESS/INDUSTRY: Restaurant

17. FATHER'S NAME (First, Middle, Last): Ht Chang

18. MOTHER'S NAME (First, Middle, Maiden Surname): Not available

19a. INFORMANT'S NAME (Type/Print): Chi Wen Kao

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12601 Celtic Court, Rockville, Maryland 20850

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park

20c. LOCATION — City or Town, State: Rockville, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michele P. Kitta M00348

22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Avenue, Rockville, Maryland 20850

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiopulmonary ~~failure~~ failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. metastatic inflammatory breast cancer

DUE TO (OR AS A CONSEQUENCE OF):

c. metastatic papillary carcinoma of thyroid

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gilbert K Lee MD

29c. LICENSE NUMBER: D31282

29d. DATE SIGNED (Month, Day, Year): ▶ 12.22.89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 8218 Wisconsin Ave, Ste 105 Bethesda, Md 20814

31. DATE FILED (Month, Day, Year): DEC 27 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37488

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harold Kisseleff				2. DATE OF DEATH (Month, Day, Year): Mar 27 89	3. TIME OF DEATH: 1:52 PM
4. SOCIAL SECURITY NUMBER: 224-62-2778	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug 11 1912	8. BIRTHPLACE (State or Foreign Country): Washington D.C.
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON MD 20735		9c. COUNTY OF DEATH: P.G. County

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Forestville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2572 Oak Glen Way		10f. ZIP CODE: 20747	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Morris Kisseleff		18. MOTHER'S NAME (First, Middle, Maiden Surname): Estelle Botkin	
19a. INFORMANT'S NAME (Type/Print): Ruth Ladd		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2572 Oak Glen Way Forestville MD 20747	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Gardens	20c. LOCATION — City or Town, State: Falls Church VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Wilhelm		22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home 4308 Suitland Road Suitland MD 20746	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Urosepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Cystocystomy	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Neurogenic Bladder	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Staph Pseudintermedia Meningitis Weakness of feet

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURRED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: 022257	29d. DATE SIGNED (Month, Day, Year): ▶ 28 Mar 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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SOUTHERN COLLEGE

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Chin C. Ling			2. DATE OF DEATH: Month Dec Day 27 Year 89	3. TIME OF DEATH: 12 [illegible] M
4. SOCIAL SECURITY NUMBER: 218-52-7300	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 99 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan 2, 1890	8. BIRTHPLACE (State or Foreign Country): China
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spg		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Bethesda	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7504 Radnor Rd.		10f. ZIP CODE: 20817	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Oriental

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Sin-Chia Keh	18. MOTHER'S NAME (First, Middle, Maiden Surname): Tung-Hai Siu
19a. INFORMANT'S NAME (Type/Print): Linda Ling Allen	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7504 Radnor Rd., Bethesda, MD 20817

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Memorial Park	20c. LOCATION — City or Town, State: Rockville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Vernon Simmons	22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, 5130 WIsconsin Av., Washington, DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or haert feilure. List only one couse on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Dis.

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John S. Rogers, M.D.	29c. LICENSE NUMBER: D09915	29d. DATE SIGNED (Month, Day, Year): Dec 27, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John S. Rogers, M.D. 1919 Seminary Rd. Silver Spring, MD

31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death and signed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joyce L. Argo Lloyd			2. DATE OF DEATH (Month, Day, Year): 12-27-89	3. TIME OF DEATH: 1 p M
4. SOCIAL SECURITY NUMBER: 221-28-6543	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 05-07-44	8. BIRTHPLACE (State or Foreign Country): Chestertown
9a. FACILITY NAME (If not institution, give street and number): Union Hospital Of Cecil County		9b. CITY, TOWN OR LOCATION OF DEATH: Elkton		9c. COUNTY OF DEATH: Cecil
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Earleville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 29 Kent Road Box 112		10f. ZIP CODE: 21919		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES:	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager		16b. KIND OF BUSINESS/INDUSTRY: Chesapeake City V.F.W.
17. FATHER'S NAME (First, Middle, Last): Cortlen H. Argo		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Taylor		
19a. INFORMANT'S NAME (Type/Print): William Lloyd		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 29 Kent Rd. Box 112 Earleville, Md. 21919		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Capital Crematory		20c. LOCATION — City or Town, State: Dover, Delaware
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B. Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home Box 270 Millington, Md. 21651		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Barbara A. Sauers MD	D25915	▶ 12-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Cecil-Kent Health Ctr. Cecilton, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 '90	Julia Davidson-Randall

15

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

89 37491 REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Clara Agnes Leanord			2. DATE OF DEATH (Month, Day, Year): 12/28/89	3. TIME OF DEATH: 4:25 pm M
4. SOCIAL SECURITY NUMBER: 218 - 52 - 7250	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 5, 1900	8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number): GLNH		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince George
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14200 Laurel Park Drive		10f. ZIP CODE: 20707		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 6; College (1-4 or 8+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): William A. Miles		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Snapp		
19a. INFORMANT'S NAME (Type/Print): William Fisher		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Orchard Town Court Laurel, Maryland 20707		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery		20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature] F.D.		22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ORGANIC BRAIN SYNDROME; FRACTURE RIGHT FEMUR

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A; 28b. TIME OF INJURY: M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED: N/A
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D24997	▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Luis A. Casas 8317 Cherry Lane Laurel, Maryland 20707

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 '90	Julia Davidson-Randall

10

DHMH-16 Rev 1/89

89 37492

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
SAMUEL	LAIGLE	12 30 89	8:46 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR / IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	1 [X] M 2 [ ] F	YRS.	MONTHS 01 DAYS 26 HOURS MIN.	Nov 5, 1989	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Malcolm Grow U.S.A.F. Hospital	Camp Springs	Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George	Morningside	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4505 Maple Road	20746	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
N/A		N/A	

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Pascal Laigle	Sheri Lyman

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Sheri Laigle	4505 Maple Road Morningside, Maryland 20746

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Ivy Hill Cemetery	Laurel, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Sudden Infant Death Syndrome	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 12-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Margarita A. Korell, M.D.-Assistant 111 Penn Street Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 '90	Julia Davidson-Randall

OHMH-16 Rev 1/89

89 37493

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PAUL JOSEPH LYNCH			2. DATE OF DEATH (Month, Day, Year): DEC. 31, 1989	3. TIME OF DEATH: 8:45 A M
4. SOCIAL SECURITY NUMBER: 215 20 5416	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5/13/26	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): DOA FROSTBURG COMMUNITY HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH: FROSTBURG	9c. COUNTY OF DEATH: ALLEGANY	
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: ALLEGANY	10c. CITY, TOWN OR LOCATION: FROSTBURG	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 263 CENTENNIAL STREET		10f. ZIP CODE: 21532	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): PRODUCE MANAGER	16b. KIND OF BUSINESS/INDUSTRY: A & P FOOD STORE		
17. FATHER'S NAME (First, Middle, Last): JOSEPH LYNCH		18. MOTHER'S NAME (First, Middle, Maiden Surname): EMMA MAUREY		
19a. INFORMANT'S NAME (Type/Print): MRS. DEBBIE COSTELLO		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 147 CENTENNIAL ST., FROSTBURG, MD 21532		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. MICHAEL'S CEMETERY	20c. LOCATION — City or Town, State: FROSTBURG, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marilou M. Sowers		22. NAME AND ADDRESS OF FACILITY: SOWERS FUNERAL HOME, 60 W. MAIN ST. FROSTBURG, MD 21532		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	MYOCARDIAL INFARCTION	15 MIN.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CORONARY ARTERY DISEASE	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Giovanni Mastrangelo DEPUTY MED. EX.	DO7098	▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GIOVANNI MASTRANGELO, M.D. 900 SETON DRIVE, CUMBERLAND, MD 21502

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 05 1990	Julia Davidson-Randall

DHMH-16 Rev 1/89

7

89 37494

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LUCY LAY			2. DATE OF DEATH (Month, Day, Year): DECEMBER 26, 1989	3. TIME OF DEATH: 10 A M
4. SOCIAL SECURITY NUMBER: 407-18-0085	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): MAY 25, 1910	8. BIRTHPLACE (State or Foreign Country): KENTUCKY
9a. FACILITY NAME (If not institution, give street and number): CARRIAGE HILL NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: KENTUCKY	10b. COUNTY: WHITLEY	10c. CITY, TOWN OR LOCATION: WILLIAMSBURG	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: SOUTH SECOND STREET		10f. ZIP CODE: 40769	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): JOSH RAINS		18. MOTHER'S NAME (First, Middle, Maiden Surname): MYRTLE JOHNSON	
19a. INFORMANT'S NAME (Type/Print): BARBARA STRUNK DAUGHTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5454 MARLIN STREET ROCKVILLE, MARYLAND 20853		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): HIGHLAND CEMETERY	20c. LOCATION — City or Town, State: WILLIAMSBURG, KENTUCKY	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Karen O'Bond	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BOULEVARD, W.SIL.SPR., MD. 2090		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coreno Vascular accident	2 months
	DUE TO (OR AS A CONSEQUENCE OF): b. Open Heart Surgery, Mitral Valve Replacement	2 months
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): c. ~~Val~~ Congestive Heart Failure	6 months
	DUE TO (OR AS A CONSEQUENCE OF): d. Mitral Valve insufficiency.	4 year

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia Tracheostomy Pneumonia
Congestive Heart Failure.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Oliver Lawless MD	29c. LICENSE NUMBER: D25440	29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Oliver J. Lawless MD. 3801 International Drive Silver Spring		
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

89 37495

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): E. MORGAN LEISTER		2. DATE OF DEATH (Month - Day - Year): 12 - 31 - 89	3. TIME OF DEATH: 8 36 PM
4. SOCIAL SECURITY NUMBER: 215-07-5624	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-07-02
8. BIRTHPLACE (State or Foreign Country): MD			
9a. FACILITY NAME (If not institution, give street and number): CARROLL LUTHERAN VILLAGE	9b. CITY, TOWN OR LOCATION OF DEATH: WESTMINSTER	9c. COUNTY OF DEATH: CARROLL	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: WESTMINSTER	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 200 ST. LUKE CIRCLE	10f. ZIP CODE: 21157	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGH SCHOOL; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CREDIT DEPT	16b. KIND OF BUSINESS/INDUSTRY: Retail/Dept. Store	
17. FATHER'S NAME (First, Middle, Last): SAMUEL CLIFFORD LEISTER	18. MOTHER'S NAME (First, Middle, Maiden Surname): AGNES READ		
19a. INFORMANT'S NAME (Type/Print): Mrs. David L. Brauning	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2926 Baltimore Blvd., Finksburg, MD 21048		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Kriders Church	20c. LOCATION — City or Town, State: Cemetery	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.	22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd. Westminster, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE CARDIO-RESPIRATORY ARREST
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. AS H D
DUE TO (OR AS A CONSEQUENCE OF):
c. CORONARY INSUFFICIENCY
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD PHYSICIAN
29c. LICENSE NUMBER: D24827
29d. DATE SIGNED (Month, Day, Year): ▶ 1/1/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R. RICCI MD. 3125 BALTO BLVD. FINKSBORG, MD 21048

31. DATE FILED (Month, Day, Year): JAN 4 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37496

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HILDA MAE LEE.			2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 1989	3. TIME OF DEATH: 0505 M
4. SOCIAL SECURITY NUMBER: 578-54-3977	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov 15, 1924	8. BIRTHPLACE (State or Foreign Country): Virginia
8a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Tokoma Park		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Landover		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7406 Landover Rd.		10f. ZIP CODE: 20785		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): James Fountain			18. MOTHER'S NAME (First, Middle, Maiden Surname): Phyllis Carter	
19a. INFORMANT'S NAME (Type/Print): Edna P. Lee		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7406 Landover Rd. Landover, Md. 20785		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springfield Bapt. Ch. Cem.		20c. LOCATION — City or Town, State: Troy, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ James Randolph Reddy #039		22. NAME AND ADDRESS OF FACILITY: Preddy Funeral Home		P.O. Box 714 Gordonsville Va.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PNEUMONIA	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CEREBRAL INFARCT	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ATHEROSCLEROSIS	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

URINARY TRACT INFECTION
DIABETES

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO N/A	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D 19971	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. SUDHAKAR, 7610 CARROLL AVE #230, TAKOMA PARK MD 20912		
31. DATE FILED (Month, Day, Year): JAN 19 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37497

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dewey Wilton Lewis Lewis				2. DATE OF DEATH (Month, Day, Year): December 31 1989	3. TIME OF DEATH: 0630 AM
4. SOCIAL SECURITY NUMBER: 513-10-0871	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/3/1916	8. BIRTHPLACE (State or Foreign Country): Oklahoma
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 XX YES 2 ☐ NO
10e. STREET AND NUMBER: 724 Race Street		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck Driver	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Millard Filmore Lewis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pearl Devine	
19a. INFORMANT'S NAME (Type/Print): Anna Marie Lewis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 724 Race St. Cambridge, Md. 21613	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery	20c. LOCATION — City or Town, State: Federalsburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio pulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. neurogenic bladder, hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. questionable peroneal ataxia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. hypertension + dement NF	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: metal cancer, COPD, hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 31887	29d. DATE SIGNED (Month, Day, Year) ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rosenbluth		
31. DATE FILED (Month, Day, Year): 12/31/89 JAN 2 '90	32. REGISTRAR'S SIGNATURE: Walter Rosenbluth Julia Davidson-Randall	

DHMH 16 Rev 1/89

89 37498

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Roy Leon LOUK (Roy Leon Louk)
2. DATE OF DEATH: MONTH 12 DAY 31 YEAR 89
3. TIME OF DEATH: 0815 A-M
4. SOCIAL SECURITY NUMBER: 282-38-0145
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday): 47 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01/21/42
8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 514 W. Franklin St.
10f. ZIP CODE: 21740
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): -
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): manager
16b. KIND OF BUSINESS/INDUSTRY: service station
17. FATHER'S NAME (First, Middle, Last): Sterl Louk
18. MOTHER'S NAME (First, Middle, Maiden Surname): Zella Bender
19a. INFORMANT'S NAME (Type/Print): Cynthia Louk
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 514 W. Franklin St., Hagerstown, Md. 21740
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greenlawn Memorial Park
20c. LOCATION — City or Town, State: Williamsport, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich
22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LARGE CELL CARCINOMA OF LUNG	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE PULMONARY DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Could not be determined 6 ☐ Pending Investigation
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: David J Delaporta MD.
29c. LICENSE NUMBER: D26523
29d. DATE SIGNED (Month, Day, Year) ▶ 1/3/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 703 OAK HILL AVENUE, HAGERSTOWN MARYLAND 21740
31. DATE FILED (Month, Day, Year): JAN 05 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-16 Rev 1/89

89 37499

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HERBERT W. LAU			2. DATE OF DEATH (Month, Day, Year): DECEMBER 22 89	3. TIME OF DEATH: 4:08 A M
4. SOCIAL SECURITY NUMBER: 188-03-3438	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 11, 1908	8. BIRTHPLACE (State or Foreign Country): York Pa
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY		9c. COUNTY OF DEATH: PRINCE GEORGE'S
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Hyattsville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4915 66th Avenue		10f. ZIP CODE: 20784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Repairman		16b. KIND OF BUSINESS/INDUSTRY: Sears and Roebuck Co.
17. FATHER'S NAME (First, Middle, Last): Harry Lau		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lottie Cronister		
19a. INFORMANT'S NAME (Type/Print): Ruth Lau		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4915 66th Avenue Hyattsville, Md 20784		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery		20c. LOCATION — City or Town, State: Brentwood Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christine L. Kopczyk		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home 4739 Baltimore Avenue Baltimore Ave 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Anoxic Encephalopathy.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Intracranial bleed	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alcohol Abuse
Hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [X] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12/11	28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: pt was found unresponsive	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ramin Patel PA-C	29c. LICENSE NUMBER: D37243	29d. DATE SIGNED (Month, Day, Year): ▶ 12/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

(12)

89 3744

89 37500

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVERETT LANTZ			2. DATE OF DEATH (Month, Day, Year): 12-20-1989	3. TIME OF DEATH: 10:55 p.m.
4. SOCIAL SECURITY NUMBER: 578-20-0275	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 68 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept/15/1921	8. BIRTHPLACE (State or Foreign Country): West VA
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON		9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Suitland	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3829 St Barnabas Road #T3		10f. ZIP CODE: 20746	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): mechanic	16b. KIND OF BUSINESS/INDUSTRY: sand and gravel	
17. FATHER'S NAME (First, Middle, Last): George Lantz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Chandler	
19a. INFORMANT'S NAME (Type/Print): Margaret Lantz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3829 St Barnabas Road T3 Suitland MD 20746		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Wilhelm	22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home, Inc Suitland MD 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma of the lung, Stage III	4 yrs. 11 mos
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD.	29c. LICENSE NUMBER: D(4730	29d. DATE SIGNED (Month, Day, Year): ▶ 12-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37501

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ellen O. Lilya			2. DATE OF DEATH (Month, Day, Year): 12 - 29- 89	3. TIME OF DEATH: 5:35 A M
4. SOCIAL SECURITY NUMBER: 217-10-1018	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-4-1897	8. BIRTHPLACE (State or Foreign Country): OHIO
9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY CO.
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: ALLEGHENY CO.	10c. CITY, TOWN OR LOCATION: CUMBERLAND		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 913- ZIHLMAN		10f. ZIP CODE: UNKNOWN		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES XX	13. WAS DECEHDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): REGISTERED NURSE		16b. KIND OF BUSINESS/INDUSTRY: NURSING	
17. FATHER'S NAME (First, Middle, Last): HERMAN F. LILYA		18. MOTHER'S NAME (First, Middle, Maiden Surname): BEDA CHRISTIANA ECK		
19a. INFORMANT'S NAME (Type/Print): REV.DR. REICHARD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701-VEIRS DR.,ROCKVILLE,MD. 20850		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ROSE HILL CEMETERY		20c. LOCATION — City or Town, State: CUMBERLAND,MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ William M. Hysong		22. NAME AND ADDRESS OF FACILITY: THE HYSONG CO.,INC. 1300- N STREET, N.W. WASH.,DC 20005		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Biliary Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. #	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. NK	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Atherosclerotic Heart Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NK	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward J Davis	29c. LICENSE NUMBER: D33677	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward J Davis, MD 19721 Executive Park Circle Germantown MD 20874

31. DATE FILED (Month, Day, Year): 12/29/89 JAN 8 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37502

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances P. Miller		2. DATE OF DEATH (Month, Day, Year): Dec. 31, 1989	3. TIME OF DEATH: 10:30 PM M
4. SOCIAL SECURITY NUMBER: 577-12-7407	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan 14, 1915
8. BIRTHPLACE (State or Foreign Country): Ohio			
9a. FACILITY NAME (If not institution, give street and number): Potomac Valley Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Derwood	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 15713 Indianola Drive	10f. ZIP CODE: 20855	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Farming	
17. FATHER'S NAME (First, Middle, Last): Joseph Pohzell	16. MOTHER'S NAME (First, Middle, Maiden Surname): Maude (not available)		
19a. INFORMANT'S NAME (Type/Print): Andrew J. Miller	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15713 Indianola Drive Derwood, Maryland 20855		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.	20c. LOCATION — City or Town, State: Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶Robert J. Farrah M00198	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Parkinsons Disease	2 YRS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D01120	29d. DATE SIGNED (Month, Day, Year): ▶2 JAN 1990

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Walter E. Goozh, M.D. 2309 Shorefield Road Wheaton, Maryland 20902

31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell

DHMH-18 Rev 1/89

89 37503

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(5)

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Amelia Allen MORTON			2. DATE OF DEATH (Month, Day, Year): December 25, 1989	3. TIME OF DEATH: 10:55 A M
4. SOCIAL SECURITY NUMBER: 218-54-8476	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 28, 1913	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): AMI Doctors' Hosp. of Pr. Geo. Cty		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince Georges
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Riverdale		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6607 60th Avenue		10f. ZIP CODE: 20737		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: P.G. Board of Education		
17. FATHER'S NAME (First, Middle, Last): Marion Clay Allen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie Hazen Beron		
19a. INFORMANT'S NAME (Type/Print): Elizabeth Kendall (Daughter)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6607 60th Avenue, Riverdale, Maryland 20737		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jack D Friend	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of Lung, Small cell type	about 2mo
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive Pulmonary Disease	about 2 yrs.
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
William D. Rosson, MD		▶ 12-26-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM D. ROSSON, MD 5701 85TH AVE NEW CARROLLTON, MD 20784

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Julie Davidson-Randall

DHMH-16 Rev 1/89

89 37504

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be completed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HENRY MARKOE					2. DATE OF DEATH (Month / Day / Year): 12 / 27 / 89	3. TIME OF DEATH: 5:15 A M
4. SOCIAL SECURITY NUMBER: 114-01-9488	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-22-1906	8. BIRTHPLACE (State or Foreign Country): NEW YORK
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT						
10a. STATE: NEW YORK	10b. COUNTY: NEW YORK		10c. CITY, TOWN OR LOCATION: NEW YORK		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 140 7th AVE			10f. ZIP CODE: 10011		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced XX	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO XX IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO XX Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 8+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANUFACTURER		16b. KIND OF BUSINESS/INDUSTRY: JEWELRY INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): HARRY MARKOE			18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA LAZINSKY			
19a. INFORMANT'S NAME (Type/Print): JUDITH MARKOE			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1515 Q STREET N.W.:WASHINGTON D.C. 20009			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW MONTEFIORE CEMETERY		20c. LOCATION — City or Town, State: PINELAWN,NEW YORK	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Frankel Stone			22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE:ROCKVILLE,MD 20852			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Complications of multiple injuries
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Severe arteriosclerotic cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
5-4-89	M	1 [ ] YES 2 [X] NO	Driver in auto/auto impact

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): road

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 21st St. & 8th Ave., New York City, N.Y.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 12-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant 111 Penn Street BAltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	

DHMH-18 Rev 1/89

89 37505

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Perry E Milton			2. DATE OF DEATH (Month, Day, Year): December 31, 1989	3. TIME OF DEATH: 11:00P.M
4. SOCIAL SECURITY NUMBER: 216-14-9105	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-5-1919	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Talbot	10c. CITY, TOWN OR LOCATION: Royal Oak	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Box 46		10f. ZIP CODE: 21662	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: Dec. 22, 1942 — 11-4-45	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): College	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Perry Comodore Milton		18. MOTHER'S NAME (First, Middle, Maiden Surname)	
19a. INFORMANT'S NAME (Type/Print): Mary Alice Martin Milton		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 46 Royal Oak, Md. 21662	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Md. V.A. Beulah	20c. LOCATION — City or Town, State: Beulah, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie Smith		22. NAME AND ADDRESS OF FACILITY: Bennie Smith Funeral Home	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. HYPOTENSION	72 HOURS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. SEPSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

QUADRIPLEGIA
CARDIOMYOPATHY

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: XX Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: C.W. Bain M.D.	29c. LICENSE NUMBER: D00250	29d. DATE SIGNED (Month, Day, Year): ▶ 1/ /89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Callum Bain M.D. 415 E. Dover street, Easton, Md. 21601

31. DATE FILED (Month, Day, Year): JAN · 9 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Pages 1, 2, 3 should be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 or page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the state.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37506

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ralph Norton Mench			2. DATE OF DEATH (Month, Day, Year): Dec 26 1989	3. TIME OF DEATH: Approx 400 AM
4. SOCIAL SECURITY NUMBER: 215-12-6681	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06-11-23	8. BIRTHPLACE (State or Foreign Country): Rock Hall
9a. FACILITY NAME (If not institution, give street and number): 1880 Crystal Beach Rd.		9b. CITY, TOWN OR LOCATION OF DEATH: Earleville		9c. COUNTY OF DEATH: Cecil County

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Cecil	10c. CITY, TOWN OR LOCATION: Earleville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1880 Crystal Beach Road		10f. ZIP CODE: 21919	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES: X	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 yrs; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brick Mason	16b. KIND OF BUSINESS/INDUSTRY: Masonry	
17. FATHER'S NAME (First, Middle, Last): Henry Devoid Mench		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Coleman	
19a. INFORMANT'S NAME (Type/Print): Marcelle Mary Mench		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1880 Crystal Beach Road Earleville, Md. 21919	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Chapel Cemetery	20c. LOCATION — City or Town, State: Rock Hall, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary B. Fellows		22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home Box 270 Millington, Md. 21651	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alcoholic liver disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Asst Deputy Medical Examiner	29c. LICENSE NUMBER: D17691	29d. DATE SIGNED (Month, Day, Year): Dec 26 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Juan C. Gonzalez-Vitaly MD Union Hospital, Elkton MD 21921

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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DHMH-16 Rev 1/89

89 37507

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THERESA MROZINSKI
2. DATE OF DEATH (Month, Day, Year): 12/29/89
3. TIME OF DEATH: 5:00 PM
4. SOCIAL SECURITY NUMBER: 215-03-3305
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 91 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/16/98
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): CHURCH HOSPITAL CORPORATION
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE CITY
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 813 S. ELLWOOD AVE.
10f. ZIP CODE: 21224
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): RETIRED
16b. KIND OF BUSINESS/INDUSTRY: FACTORY WORK
17. FATHER'S NAME (First, Middle, Last): JOHN PLUCINSKI
18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY UNKNOWN
19a. INFORMANT'S NAME (Type/Print): MARLENE PARKS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 813 S. ELLWOOD AVE. BALTO., MD. 21224
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. STANISLAUS CEM.
20c. LOCATION — City or Town, State: BALTO., MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Thomas J. Skarda Jr.
22. NAME AND ADDRESS OF FACILITY: HOFFMANN-SKARDA 3218 HUDSON ST.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN DEATH. SUDDEN DEATH
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. HASCVD HASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: David J. Seff MD
29c. LICENSE NUMBER: N/A
29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DAVID J SEFF MD — DR. DAVID J. SEFFK, M.D. CHURCH HOSPITAL
31. DATE FILED (Month, Day, Year): 12/29/89
32. REGISTRAR'S SIGNATURE: JAN 5 '90 Julia Davidson-Randall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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OHMH-18 Rev 1/89

89 37508

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Betty Evans MacDonald			2. DATE OF DEATH (Month, Day, Year): December 31, 1989	3. TIME OF DEATH: 6:15 p M
4. SOCIAL SECURITY NUMBER: 005 - 18 - 8187	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 26, 1908	8. BIRTHPLACE (State or Foreign Country): Maine
9a. FACILITY NAME (If not institution, give street and number): 928 Montgomery Street		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 928 Montgomery Street		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Owner/Operator	16b. KIND OF BUSINESS/INDUSTRY: Pet Kennel	
17. FATHER'S NAME (First, Middle, Last): Daniel Davis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie unknown	
19a. INFORMANT'S NAME (Type/Print): Joseph Earl MacDonald		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 928 Montgomery Street Laurel, Maryland 20707	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ivy Hill Cemetery	20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donaldson F.H.		22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Coronary artery disease. DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Non insulin dependent diabetes. DUE TO (OR AS A CONSEQUENCE OF):	
	c. Hypertension. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Raymond E. Banker MD	29c. LICENSE NUMBER MD.: D36371	29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raymond E. Banker MD 8383 Cherry Lane, Laurel MD 20707

31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

8

OHMN-16 Rev 1/89

89 37509

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELEN MARIE SHEERIN McCARTHY

2. DATE OF DEATH (Month, Day, Year): DECEMBER 20, 1989

3. TIME OF DEATH: 11:25 a.m.

4. SOCIAL SECURITY NUMBER: 307-36-5479

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 88 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS
IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): June 23, 1901

8. BIRTHPLACE (State or Foreign Country): Indiana

9a. FACILITY NAME (If not institution, give street and number): Bethesda Retirement Center

9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Chevy Chase

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 8700 Jones Mill Rd.

10f. ZIP CODE: 20815

10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS
1 ☐ Never Married 2 ☐ Married
3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 8+): 0

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Own Home

17. FATHER'S NAME (First, Middle, Last): Simon P. Sheerin

18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Doherty

19a. INFORMANT'S NAME (Type/Print): James Rocap

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9091 Wexford Dr., Vienna, VA 22182

20a. METHOD OF DISPOSITION
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery

20c. LOCATION — City or Town, State: Arlington, Virginia

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Vernon Simmons

22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons
5130 Wisconsin av., Washington, DC 20016

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart failure	6 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Rheumatic Heart disease	
DUE TO (OR AS A CONSEQUENCE OF): c.	Mitral Insufficiency	
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic Renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH
1 ☒ Natural 5 ☐ Pending Investigation
2 ☐ Accident
3 ☐ Suicide 8 ☐ Could not be determined
4 ☐ Homicide

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: J. Blaine Fitzgerald MD

29c. LICENSE NUMBER: DO-1948

29d. DATE SIGNED (Month, Day, Year): 12/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. Blaine Fitzgerald, M.D., 8218 WIsconsin Av., Bethesda, MD 20814

31. DATE FILED (Month, Day, Year): DEC 27 89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

30

DNMM-18 Rev 1/89

89 37510

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Pink McClurkin
2. DATE OF DEATH — MONTH: 12 DAY: 28 YEAR: 89
3. TIME OF DEATH: 6:10 P M
4. SOCIAL SECURITY NUMBER: 247-82-1792
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 10/15/24
8. BIRTHPLACE (State or Foreign Country): SOUTH CAROLINA
9a. FACILITY NAME (If not institution, give street and number): 1888 Addison Rd. S.
9b. CITY, TOWN OR LOCATION OF DEATH: Capitol Hgts
9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: PRINCE GEORGE'S
10c. CITY, TOWN OR LOCATION: CAPITOL HEIGHTS
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 1818 ADDISON ROAD
10f. ZIP CODE: 20743
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 XX Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XX NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 12th grade — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCKER
16b. KIND OF BUSINESS/INDUSTRY: TRUCKING
17. FATHER'S NAME (First, Middle, Last): JAMES MCCLURKIN
18. MOTHER'S NAME (First, Middle, Maiden Surname): ALICE ROBINSON
19a. INFORMANT'S NAME (Type/Print): JOHN A. HARDY, SR.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1507 K STREET SE WASHINGTON, D.C. 20003
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHURCH CEMETERY
20c. LOCATION — City or Town, State: SOUTH WHITMIRE, CAROLINA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ P. L. Faulk
22. NAME AND ADDRESS OF FACILITY: ROLLINS FUNERAL HOME, INC. 4339 HUNT PLACE, NE WASH. D.C. 20019

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Seizure Disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Lewis Whitby MD
29c. LICENSE NUMBER: 017162
29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda Whitby MD 9556 Crain Hwy Upper Marlboro, MD 20772
31. DATE FILED (Month, Day, Year): JAN 04 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Ramsey

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 Rev 1/89

89 37511

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
WILLIAM	PAUL	MELVIN	DEC 30, 1989	3:05 a M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-28-2998	1 [X] M 2 [ ] F	66 YRS.			APR 6,1923	WASHINGTON DC

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
MIDATLANTIC NURSING CENTER	SILVER SPRING	MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
N/A	N/A	WASHINGTON D.C.	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1004 EUCLID STREET N.W.	20001	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		CARPENTER	BUILDING

17. FATNER'S NAME (First, Middle, Last)	18. MOTNER'S NAME (First, Middle, Maiden Surname)
WILLIAM MELVIN	LELIA MUSSELMAN

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
FRANCES MELVIN(SISTER IN LAW)	6804 EMERSON ST, RIVERDALE, MD 20737

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	RAMOTH CEMETERY	STAFFORD, VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶	RENDON-HALE FUNERAL HOME 9013 ANNAPOLIS RD, LANHAM, MD 20706

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LUNG CANCER	5 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Kenneth Miller MD	03386	▶ DEC 30,1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
KENNITH MILLER M.D.	18111 PRINCE PHILIP DR. OLNEY, MD 20832

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 04 '90	Julia Davidson-Randall

(12)

DHMH-16 Rev 1/89

89 37512

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Virginia Moffett		2. DATE OF DEATH (Month, Day, Year): Dec. 13 89	3. TIME OF DEATH: 9:06 P M
4. SOCIAL SECURITY NUMBER: 215-38-1243	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 15, 1907
8. BIRTHPLACE (State or Foreign Country): Virginia			
9a. FACILITY NAME (If not institution, give street and number): The Kent & Queen Anne Hospital Inc.	9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown	9c. COUNTY OF DEATH: Kent	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Massey	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Goose Haven Farm Rd1	10f. ZIP CODE: 21650	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): George Hite	18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown		
19a. INFORMANT'S NAME (Type/Print): Larry Moffett	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd 1 Millington, Md. 21651		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Bohemia Cemetery	20c. LOCATION — City or Town, State: Warwick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Gary B. Fellows	22. NAME AND ADDRESS OF FACILITY: Fellows Funeral Home 370 W. Cypress St. Millington, Md. 21651		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial infarction — minutes

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. coronary artery disease

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
C G Baumann MD.		▶ 12/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): C G. Baumann Medical Bldg Chestertown, Md 21620

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 19 '89	Julia Davidson-Randall

16

OHMH-16 Rev 1/89

89 37513

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

Elina C. Makkonen

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elina C Makkonen					2. DATE OF DEATH — MONTH: 12 DAY: 25 YEAR: 89		3. TIME OF DEATH: 8:00 P.M.
4. SOCIAL SECURITY NUMBER: 019-05-4809	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb 14 1899		8. BIRTHPLACE (State or Foreign Country): Finland
9a. FACILITY NAME (If not institution, give street and number): Mallard Bay Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge			9c. COUNTY OF DEATH: Dorchester	
RESIDENCE OF DECEDENT							
10a. STATE: MD.	10b. COUNTY: Dor.		10c. CITY, TOWN OR LOCATION: Cambridge			10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 520 Glenburn Ave.			10f. ZIP CODE: 21613			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): unknown			16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): unknown			18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown				
19a. INFORMANT'S NAME (Type/Print): Mallard Bay Nursing Home			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 520 Glenburn Ave. Cambridge Md. 21613				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crystal Lake Cem.			20c. LOCATION — City or Town, State: Gardner Mass.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]			22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge MD.				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Septic Shock Septic Shock

DUE TO (OR AS A CONSEQUENCE OF):
known Infection ethiology un-

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Infection ethiology unknown

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Organic Brain Syndrom Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
E. Tanman E. Tanman		▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 4 '90	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, [illegible] for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

89 37514

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GALEN L. MILLER				2. DATE OF DEATH (Month, Day, Year): DECEMBER 21, 1989	3. TIME OF DEATH: 1:45 P M
4. SOCIAL SECURITY NUMBER: 222-03-6336-A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JULY 5, 1905	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): RESIDENCE - MD. RT. 331			9b. CITY, TOWN OR LOCATION OF DEATH: HURLOCK		9c. COUNTY OF DEATH: DORCHESTER

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: DORCHESTER	10c. CITY, TOWN OR LOCATION: HURLOCK	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: MD ROUTE 331		10f. ZIP CODE: 21643	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TEACHER	16b. KIND OF BUSINESS/INDUSTRY: EDUCATION
17. FATHER'S NAME (First, Middle, Last): LEWIS J. MILLER		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY HOCHSTEDLER	
19a. INFORMANT'S NAME (Type/Print): VIRGINIA D. MILLER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 326, HURLOCK, MD 21643	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): UNITY WASHINGTON CEMETERY	20c. LOCATION — City or Town, State: HURLOCK, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard D. Zeller		22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME, EAST NEW MARKET, MD 21631	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA (L) Hemiparesis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Dementia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. HBP	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Glaucoma

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D26388	29d. DATE SIGNED (Month, Day, Year): 12-22-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JAN 4 '90	32. REGISTRAR'S SIGNATURE: Gisha Davidson-Randall	

DHMH-16 Rev 1/89

89 37515

1 - FOR STATE REGISTRAR KATHERINE E. NICHOLS

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Katherine Nichols / KATHERINE E. NICHOLS		2. DATE OF DEATH (Month, Day, Year): 12 30 1989	3. TIME OF DEATH: 11:45 P.M.M
4. SOCIAL SECURITY NUMBER: 214-40-4075	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/31/07
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): CHARLESTOWN RETIREMENT CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: CATONSVILLE	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: BALTIMORE	10c. CITY, TOWN OR LOCATION: CATONSVILLE	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 711 MAIDEN CHOICE LANE APT. 2102	10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO XX Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 6 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SCHOOL PRINCIPAL	15b. KIND OF BUSINESS/INDUSTRY: BALTIMORE CITY
17. FATHER'S NAME (First, Middle, Last): E. JOHN NICHOLS		18. MOTHER'S NAME (First, Middle, Maiden Surname): BESSIE K. KIEFFER	
19a. INFORMANT'S NAME (Type/Print): C. DOUGLAS RITTENHOUSE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 924 FREDERICK RD. CATONSVILLE, MD. 21228	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LOUDON PARK CEMETERY	20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: 1630 EDMONDSON AVE. CATONSVILLE, MD. 21228 LEROY M. & RUSSELL C. WITZKE FUNERAL HOME	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Breast Cancer Metastatic to Lungs	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D3405-3	▶ 12/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary Applebaum MD 711 Maiden Choice Lane 21228

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	[signature]

DHMH-15 Rev 1/89

89 37516

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained ... attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should ... be the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

25

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine H. O'Conor		2. DATE OF DEATH (Month, Day, Year): December 29, 1989	3. TIME OF DEATH: 1040 A M
4. SOCIAL SECURITY NUMBER: 577-20-0383	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 31, 1920
8. BIRTHPLACE (State or Foreign Country): Washington, DC			
9a. FACILITY NAME (If not institution, give street and number): 4601 North Park Avenue, Apt. 06	9b. CITY, TOWN OR LOCATION OF DEATH: Chevy Chase	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Chevy Chase	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 4601 North Park Avenue, Apt. 06	10f. ZIP CODE: 20815	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 3	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own home
17. FATHER'S NAME (First, Middle, Last): William J. Hickey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marie J. Merritt	
19a. INFORMANT'S NAME (Type/Print): Jerry R. O'Conor, Esq.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 21020 Georgia Avenue, Brookeville, MD 20833	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.	20c. LOCATION — City or Town, State: Bethesda, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Douglas C. Sarah M00522		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	MYOCARDIAL INFARCTION	ACUTE
DUE TO (OR AS A CONSEQUENCE OF): b.	ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	INDEF
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12/29/89	28b. TIME OF INJURY: A M	28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO
	28d. DESCRIBE HOW INJURY OCCURED: FOUND IN CHAIR		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): SEE #10	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D07099	▶ December 29, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Francis C. Mayle, M.D., 8200 Wisconsin Avenue, Bethesda, Maryland 20814

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37517

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page ... must be returned to the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, ... should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hattie Lee Phillips
2. DATE OF DEATH (Month, Day, Year): 12-31-89
3. TIME OF DEATH: 1:20 AM
4. SOCIAL SECURITY NUMBER: 214-52-0827
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 41 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-31-48
8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 202 Marshall Street
9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury Md.
9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Wico
10c. CITY, TOWN OR LOCATION: Salisbury, Md.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 202 Marshall stret - Salisbury
10f. ZIP CODE: 21801
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Blk
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): John Reid
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth V. Savage Reid
19a. INFORMANT'S NAME (Type/Print): Wesley Phillips
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 202 Marshall Street - Salisbury, Md. 21801
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springhill Memory Gardens
20c. LOCATION — City or Town, State: Hebron, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]
22. NAME AND ADDRESS OF FACILITY: Lewis N. Watson Funeral Home West Rd. Salisbury, md. 21801

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic Colon Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER: D 20507
29d. DATE SIGNED (Month, Day, Year): ▶ 1/3/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph A. GRASSO 145 E. CARROLL St SALISBURY MD
31. DATE FILED (Month, Day, Year): JAN 3 '90
32. REGISTRAR'S SIGNATURE: [signature]

4

DHMH-16 Rev 1/89

89 37518

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Thomas Hansel Parks~~ Thomas Hansel Parks
2. DATE OF DEATH (Month, Day, Year): 12 12 27 1989
3. TIME OF DEATH: 9 A M
4. SOCIAL SECURITY NUMBER: 218-05-8410
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 6-24-06
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Home-XXXXXXXXXXXXXXXXXXXXXXXX
9b. CITY, TOWN OR LOCATION OF DEATH: Fishing Creek
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Fishing Creek
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: N/A
10f. ZIP CODE: 21634
10g. CITIZEN OF WHAT COUNTRY?: US
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 XX Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman
16b. KIND OF BUSINESS/INDUSTRY: Seafood
17. FATHER'S NAME (First, Middle, Last): Thomas Parks
18. MOTHER'S NAME (First, Middle, Maiden Surname): Matilda Dixon
19a. INFORMANT'S NAME (Type/Print): William Hansel Parks
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 106 Fishing Creek, Md. 21634
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): E. New Market Cemetery
20c. LOCATION — City or Town, State: E. New Market, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Cardiorespiratory arrest

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF): Possible M.I.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Possible M.I.
DUE TO (OR AS A CONSEQUENCE OF): Coronary heart disease.
c. Coronary H. Dis.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHF (controlled) CHF (controlled)

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Eyup Tanman, M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Eyup Tanman, M.D. 17 Franklin Street Cambridge, Maryland 21613
31. DATE FILED (Month, Day, Year): JAN 10 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

4

89 37519

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be [illegible] hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page [illegible] for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified in all c[illegible]

2

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn Pierce		2. DATE OF DEATH (Month, Day, Year): 12 25 89	3. TIME OF DEATH: 5 [illegible] M
4. SOCIAL SECURITY NUMBER: 218-58-2289	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 79 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 6/30/10
8. BIRTHPLACE (State or Foreign Country): Maryland.			
9a. FACILITY NAME (If not institution, give street and number): East Sh Home Center, Cambridge Md 21613	9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge, Md 21613	9c. COUNTY OF DEATH: Dorchester	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Queen Anne	10c. CITY, TOWN OR LOCATION: Chester	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER:	10f. ZIP CODE: 21619	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Travis Pierce	18. MOTHER'S NAME (First, Middle, Maiden Surname): Henrietta Wallace
19a. INFORMANT'S NAME (Type/Print): Thomas Pierce	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 217 Chester, Md. 21619

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Cemetary	20c. LOCATION — City or Town, State: Stevensville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith	22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services PO Box 928 Hurlock, Md. 21643	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the endometrium	
	DUE TO (OR AS A CONSEQUENCE OF): generalized abdominal metastasis	4 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George H. Beck MD State physician	29c. LICENSE NUMBER: DO 4867	29d. DATE SIGNED (Month, Day, Year) ▶ 12/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GEORGE H. BECK MD		
31. DATE FILED (Month, Day, Year): 1 JAN - 9 '90	32. REGISTRAR'S SIGNATURE: [illegible]	

DHMH-16 Rev 1/89

89 37520

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours; state law requires that page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary F. Pierce				2. DATE OF DEATH (Month / Day / Year): 12 / 26 / 89	3. TIME OF DEATH: 7:10AM M
4. SOCIAL SECURITY NUMBER: 220-01-1449	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-20-95	8. BIRTHPLACE (State or Foreign Country): Md
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Md	10b. COUNTY: Talbot	10c. CITY, TOWN OR LOCATION: Cordova	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route #1 Box 278		10f. ZIP CODE: 21625	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): George Flamer	18. MOTHER'S NAME (First, Middle, Maiden Surname): Vesta Willis
19a. INFORMANT'S NAME (Type/Print): Frances Pierce	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R#1 Box 278 Cordova md 21625

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Chapel	20c. LOCATION — City or Town, State: Cordova Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Joseph H. Goodwin	22. NAME AND ADDRESS OF FACILITY: 319 Dover St. Easton Md	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	pneumonia	11 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	severe malnutrition	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.	senile dementia (Alzheimer's Disease)	years
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Anemia, Microcytic

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J. Fisher MD (FISHER, M.J.)	29c. LICENSE NUMBER: D31687	29d. DATE SIGNED (Month, Day, Year) ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): JAN - 4 '90	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Bonds

DHMH-16 Rev 1/89

89 37521

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lottie Lee Panagos			2. DATE OF DEATH: Month 12 Day 23 Year 89	3. TIME OF DEATH: 10 50 A.M.
4. SOCIAL SECURITY NUMBER: 228-72-1347	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 91 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): April 13, 1898	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 19443 Brassie Place		10f. ZIP CODE: 20879	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Jeff Davis Womack		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lucy Snead	
19a. INFORMANT'S NAME (Type/Print): Ethel C. Hill	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19443 Brassie Place, Gaithersburg, MD. 20879		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): National Memorial Park	20c. LOCATION — City or Town, State: Falls Church, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michele P. Fitta M00348	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):	1 day
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.	arteriosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF):	4 yrs
c.	DUE TO (OR AS A CONSEQUENCE OF):	
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

multiple CVA
seizure disorder

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D557	29d. DATE SIGNED (Month, Day, Year): ▶ 12-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4115 Colie DR. Wheaton, MD 20906		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

3

89 37522

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE ALBERT POWITZ			2. DATE OF DEATH (Month, Day, Year): Dec. 29, 1989	3. TIME OF DEATH: 11:05 PM M
4. SOCIAL SECURITY NUMBER: 213-10-8750	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 29, 1908	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 339 Princeton Lane		9b. CITY, TOWN OR LOCATION OF DEATH: Bel Air		9c. COUNTY OF DEATH: Harford

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Bel Air	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 339 Princeton Lane		10f. ZIP CODE: 21014	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manager	16b. KIND OF BUSINESS/INDUSTRY: Armored Carrier	
17. FATHER'S NAME (First, Middle, Last): George William Powitz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hannah Cecelia Crafton	
19a. INFORMANT'S NAME (Type/Print): Georgia L. Classon		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 339 Princeton Lane, Bel Air, Md. 21014	
20a. METHOD OF DISPOSITION: [X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dulaney Valley Memorial Gardens	20c. LOCATION — City or Town, State: Timonium, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CHRONIC LYMPHOCYTIC LEUKEMIA	~2YR
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN F. EDWARDS, MD 312 BELAIR RD FALLSTON MARYLAND 21047		
31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 37523

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDITH Pumphrey		2. DATE OF DEATH (Month, Day, Year): 12 25 89	3. TIME OF DEATH: 642 AM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9-10-11
8. BIRTHPLACE (State or Foreign Country): Washington DC			

9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Clinton	9c. COUNTY OF DEATH: Prince George

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Temple Hills	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5607 Kenwood Street	10f. ZIP CODE: 20748	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): Charles Blum	18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Reckeweg		
19a. INFORMANT'S NAME (Type/Print): Nelson Pumphrey	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5607 Kenwood Street Temple Hills, MD 20748		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Wilhelm	22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home Suitland MD 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ACUTE RESPIRATORY FAILURE
DUE TO (OR AS A CONSEQUENCE OF):
b. TRACHEAL STENOSIS
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Attending physician	29c. LICENSE NUMBER: D19431	29d. DATE SIGNED (Month, Day, Year): ▶ 12/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): Frank M. Ryan M.D. 940 Justabless High Ft. Wash Md 20744		
31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

89 37524

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Paul Xavier Peltier			2. DATE OF DEATH (Month, Day, Year): December 29, 1989	3. TIME OF DEATH: 12:15 AM
4. SOCIAL SECURITY NUMBER: 217-44-2303	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 87 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 21, 1902	8. BIRTHPLACE (State or Foreign Country): Massachusetts
9a. FACILITY NAME (If not institution, give street and number): Magnolia Gardens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Lanham		9c. COUNTY OF DEATH: Prince George's
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Seabrook		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER: 6901 100th Avenue		10f. ZIP CODE: 20706		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+): 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Entomologist		16b. KIND OF BUSINESS/INDUSTRY: Dept. of Agriculture
17. FATHER'S NAME (First, Middle, Last): Paul Peltier		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Bilger		
19a. INFORMANT'S NAME (Type/Print): Mildred H. Peltier		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6901 100th Avenue, Seabrook, Md. 20706		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ft. Lincoln Cemetery		20c. LOCATION — City or Town, State: Brentwood, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Mark G. Buhrmann		22. NAME AND ADDRESS OF FACILITY: FRANCIS GASCH'S SONS FUNERAL HOME 4739 Balt. Ave., Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
S. Trifoglio MD for Dr. Yablonowitz	D37934	▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. Trifoglio MD 7500 Greenway Center Drive #430 Greenbelt MD 20770

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

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89 37525

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank Edward Quinn				2. DATE OF DEATH (Month, Day, Year): 12 23 89	3. TIME OF DEATH: 4:20 P M
4. SOCIAL SECURITY NUMBER: 084 09 0143	5. SEX: 1 ☐ M 2 ☐ F (XX)	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5 15 08	8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): 11301 Cloverhill Dr.			9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring, Md.		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 ☐ NO
10e. STREET AND NUMBER: 11301 Cloverhill Dr.		10f. ZIP CODE: 20902	10g. CITIZEN OF WHAT COUNTRY?: U S A

11. MARITAL STATUS: 1 ☐ Never Married 2 [X] Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1944-1946	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Insurance Manager	16b. KIND OF BUSINESS/INDUSTRY: Veterans Administration

17. FATHER'S NAME (First, Middle, Last): Richard Quinn	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Stack
19a. INFORMANT'S NAME (Type/Print): Catherine B. Quinn	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11301 Cloverhill Dr. Silver Spring Md. 20902

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 [X] Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory	20c. LOCATION — City or Town, State: Alexandria Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Sil. Spr. Md. 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Massive Gastrointestinal Bleeding	1 day
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Metastatic Carcinoma	months
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 [X] Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D557	29d. DATE SIGNED (Month, Day, Year) ▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. T. Benack MD. 4115 Colie Dr. Wheaton, Md 20906

31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

4041

DHMH-18 Rev 1/89

89 37525

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89 37526

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 shall be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified on page 5.

1. DECEDENT'S NAME (First, Middle, Last): Rosie L Rawlings ROSIE LEA RAWLINGS					2. DATE OF DEATH MONTH 12 DAY 27 YEAR 89		3. TIME OF DEATH 6:10 PM
4. SOCIAL SECURITY NUMBER: 577-22-6185	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): JAN. 12, 1915		8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): HARBOR HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY		9c. COUNTY OF DEATH: N/A		
RESIDENCE OF DECEDENT							
10a. STATE: MARYLAND	10b. COUNTY: ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION: GLEN BURNIE			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO		
10e. STREET AND NUMBER: 423 WELLHAM AVENUE		10f. ZIP CODE: 21061			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY: N.S.A.				
17. FATHER'S NAME (First, Middle, Last): HOWARD JOSEPH HENDLEY			18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE ELLEN BEAL				
19a. INFORMANT'S NAME (Type/Print): BARBARA LEA WYVILL (DAUGHTER)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10402 TRUXTON ROAD, ADELPHI, MARYLAND 20783						
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GATE OF HEAVEN CEMETERY	20c. LOCATION — City or Town, State: SILVER SPRING, MARYLAND					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael L. Boyle	22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W., SIL. SP., MD 20901						

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	1 wk.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Renal Failure	1 wk.
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Metastatic Rectal carcinoma	1 yr.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert Dent M. MD		▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Dent 3001 S. Hanover St. Balt., MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
12/27/89 JAN 3 '90	RT Julia Davidson-Randall

20

DHMH-16 Rev 1/89

89 37526

89 37527

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Claire W. Rich		2. DATE OF DEATH (Month, Day, Year): December 29, 1989	3. TIME OF DEATH: 12:45 PM M
4. SOCIAL SECURITY NUMBER: 161-26-8933	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar. 1, 1933
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): Prince George's General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly, Maryland	9c. COUNTY OF DEATH: Prince George	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George	10c. CITY, TOWN OR LOCATION: Bowie	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2915 Stonybrook Drive	10f. ZIP CODE: 20715	10g. CITIZEN OF WHAT COUNTRY?: United States	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Manager	16b. KIND OF BUSINESS/INDUSTRY: Medical Doctor	
17. FATHER'S NAME (First, Middle, Last): August Wollner	18. MOTHER'S NAME (First, Middle, Maiden Surname): Kathryn Ratchford		
19a. INFORMANT'S NAME (Type/Print): David E. Rich	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as # 10.		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MD Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Evans Pres	22. NAME AND ADDRESS OF FACILITY: Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowei, MD 20715		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. intracerebral hemorrage	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Myocardial infarction, thrombolytic therapy	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Dobin MD	29c. LICENSE NUMBER: D34403	29d. DATE SIGNED (Month, Day, Year): ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Andrew Dobin MD 3231 Superior Lane Bowie MD		
31. DATE FILED (Month, Day, Year): 12 JAN 09 90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

15

89 37528

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MYRTLE ROBERTS / MYRTLE FRANCES ROBERTS			2. DATE OF DEATH (Month, Day, Year): 12 27 09	3. TIME OF DEATH: 840 P M
4. SOCIAL SECURITY NUMBER: 579-20-0054	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08 02 05	8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): GREATER LAUREL BELTSVILLE HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH

RESIDENCE OF DECEDENT

10a. STATE: Virginia	10b. COUNTY	10c. CITY, TOWN OR LOCATION: Salem	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1312 Pulaski Street		10f. ZIP CODE: 24153	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ ND Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired	16b. KIND OF BUSINESS/INDUSTRY: Safeway-Washington, DC	
17. FATHER'S NAME (First, Middle, Last): Richard Lee Bohon		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Webster	
19a. INFORMANT'S NAME (Type/Print): James Richardson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1312 Pulaski Street, Salem, Virginia 24153	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Burial Park	20c. LOCATION — City or Town, State: Roanoke, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John M Oaky		22. NAME AND ADDRESS OF FACILITY: Roanoke VA	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acidosis

DUE TO (OR AS A CONSEQUENCE OF): b. possible ischemic Bowel

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF): c.

DUE TO (OR AS A CONSEQUENCE OF): d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gastrointestinal Bleeding; Peripheral vascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D29992	29d. DATE SIGNED (Month, Day, Year): 12-27-09

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): GREGORY A. COMPTON MD 8317 Cherry Lane Laurel MD 20707

31. DATE FILED (Month, Day, Year): JAN 19 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

DHMH-16 Rev 1/89

89 37529

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): J. Fred Robinson
2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89
3. TIME OF DEATH: 9:00 A M
4. SOCIAL SECURITY NUMBER: 166163690
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 80 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3/3/09
8. BIRTHPLACE (State or Foreign Country): Mt. City, Tenn.
9a. FACILITY NAME (If not institution, give street and number): 592 England Creamy Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: England Creamy, North East
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: England Creamy North East
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 592 England
10f. ZIP CODE: 21901
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown — College (1-4 or 5+): unknown
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer
16b. KIND OF BUSINESS/INDUSTRY: Farming
17. FATHER'S NAME (First, Middle, Last): Joesph Robinson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Vade Walsh
19a. INFORMANT'S NAME (Type/Print): Helen Robinson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 592 England Creamy Rd. North East, Md. 21901
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oxford Cemetery
20c. LOCATION — City or Town, State: Oxford, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert T. Ford Sr.
22. NAME AND ADDRESS OF FACILITY: R T FORD FUNERAL, Rising Sun Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hepatic Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Chronic Hepatitis, C	
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
1) Hypertensive Retinopathy c/c Cardiovascular Disease
2) Chronic Idiopathic thrombocytopenic purpura
3) Diabetes Mellitus: type I

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Sang W. Kim M.D.
29c. LICENSE NUMBER: D15103
29d. DATE SIGNED (Month, Day, Year): 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): SANG W. KIM, M.D. 308 S. Union Ave Havre de Grace, MD. 21078
31. DATE FILED (Month, Day, Year): JAN 17 1990
32. REGISTRAR'S SIGNATURE: Julie Davidson-Randall

DHMH-16 Rev 1/89

89 37530

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JULIA M. REID		2. DATE OF DEATH (Month, Day, Year): December 25 1989	3. TIME OF DEATH: 11:10 P M
4. SOCIAL SECURITY NUMBER:	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Dec/29/1905
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): REGENCY NURSING HOME	9b. CITY, TOWN OR LOCATION OF DEATH: FORESTVILLE	9c. COUNTY OF DEATH: PRINCE GEORGE	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: PRINCE GEORGE	10c. CITY, TOWN OR LOCATION: FORESTVILLE	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 7214 Earl Drive	10f. ZIP CODE: 20747	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker	16b. KIND OF BUSINESS/INDUSTRY: own home	
17. FATHER'S NAME (First, Middle, Last): Sven Larson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Augusta Carlson		
19a. INFORMANT'S NAME (Type/Print): Dolores Dyess	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7214 Earl Drive Forestville MD 20747		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery	20c. LOCATION — City or Town, State: Arlington VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Wilhelm	22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home, Inc. 4308 Suitland Rd Suitland MD 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ARTERIOSLEROCTIC HEART DISEASE	20 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	DEMENTIA	20 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	PNEUMONIA	3 days
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ~~Poor nutritional state~~

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William T Tanner MD	29c. LICENSE NUMBER:	29d. DATE SIGNED (Month, Day, Year): ▶ Dec/26/1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William T. Tanner, M.D. 11701 Livingston Road Ft Washington MD

31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37531

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARMON DAWSON RICHARDSON

2. DATE OF DEATH (Month, Day, Year): DEC. 26, 1989

3. TIME OF DEATH: 11 : 55 AM

4. SOCIAL SECURITY NUMBER: 217-10-3850

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 81 YRS.

IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): NOV. 7, 1908

8. BIRTHPLACE (State or Foreign Country): MARYLAND

9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING CENTER-THE PINES

9b. CITY, TOWN OR LOCATION OF DEATH: EASTON

9c. COUNTY OF DEATH: TALBOT

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: TALBOT

10c. CITY, TOWN OR LOCATION: BOZMAN

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: LATCHSTRING LANE

10f. ZIP CODE: 21612

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES X

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: X

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 6
College (1-4 or 8+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CARETAKER - WATERMAN

16b. KIND OF BUSINESS/INDUSTRY: SEAFOOD

17. FATHER'S NAME (First, Middle, Last): THOMAS CARROLL RICHARDSON

18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY ANN STEILKIE

19a. INFORMANT'S NAME (Type/Print): NANCY RICHARDSON

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOZMAN, MARYLAND 21612

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BOZMAN CEMETERY

20c. LOCATION — City or Town, State: BOZMAN , MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harrison E. Leonard

22. NAME AND ADDRESS OF FACILITY: HARRIOSN E. LEONARD FUNERAL HOME 21663
312 S. TALBOT ST. S T MICHAELS, MARYLAND

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Urinary Tract Infection	1wk
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Sepsis	2 weeks
c. DUE TO (OR AS A CONSEQUENCE OF):	Arteriosclerotic Cardiovascular Disease	many years
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R. Lane Wroth, MD

29c. LICENSE NUMBER: D11308

29d. DATE SIGNED (Month, Day, Year): ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print): R. LANE WROTH M.D. ST. MICHAELS, MARYLAND 21663

31. DATE FILED (Month, Day, Year): DEC 28 '89

32. REGISTRAR'S SIGNATURE: Judie Davidson Pondelick

DNMH-18 Rev 1/89

89 37532

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BRADY A. ROACH					2. DATE OF DEATH (Month / Day / Year): 12 / 27 / 89	3. TIME OF DEATH: 4:01 AM
4. SOCIAL SECURITY NUMBER: 214-12-6647	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 1-10-1921	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Easton Memorial			9b. CITY, TOWN OR LOCATION OF DEATH: Easton			9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. #2 Box 114A		10f. ZIP CODE: 21632		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): George Roach		18. MOTHER'S NAME (First, Middle, Maiden Surname): Cassie Collins		
19a. INFORMANT'S NAME (Type/Print): Lydia Roach		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. #2 Box 114A Federalsburg, Md. 21632		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Federal Hill Cemetery		20c. LOCATION — City or Town, State: Federalsburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith		22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services P.O. Box 928 Hurlock, Md. 21643		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CONGESTIVE CARDIOMYOPATHY	MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. DIABETES MELITUS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
K.J. O'Keefe MD	D35259	▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KEVIN J. O'KEEFE, M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
12/27/89 JAN 5 '90	Julie Davidson-Randall

DHMH-16 Rev 1/89

89 31535

89 37533

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARIO LUIS REY
2. DATE OF DEATH: MONTH 12 DAY 26 YEAR 89
3. TIME OF DEATH: 1:50 A M
4. SOCIAL SECURITY NUMBER: Unavailable
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 19 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 27, 1970
8. BIRTHPLACE (State or Foreign Country): Mexico
9a. FACILITY NAME (If not institution, give street and number): Southern Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: P. G. Co.
10c. CITY, TOWN OR LOCATION: Upper Marlboro
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 9900 Dale Drive
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [X] YES 2 [ ] NO Specify: Mexican
14. RACE — American Indian, Black, White, etc. Specify: Mexican
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Vern Avon Rey
18. MOTHER'S NAME (First, Middle, Maiden Surname): Guadulupe Angel
19a. INFORMANT'S NAME (Type/Print): Thelma Rey (sister)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6233 Belmar Dr., El Paso, TX 79912
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Galena Cemetery
20c. LOCATION — City or Town, State: Chihuahua, Mexico
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: David L. Sawtell
22. NAME AND ADDRESS OF FACILITY: Capitol Funeral Service, Falls Church, VA

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 12-26-89
28b. TIME OF INJURY: 12:05a M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED: Pedestrian struck by vehicles
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street
28f. LOCATION (Street and Number or Rural Route Number, City, Town, State): Northbound Rt. 301 of N. Marlton Ave., Upper Marlboro, MD.
29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): 12-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant 111 Penn Street Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): JAN 4 - '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

89 37534

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) STEWART FULLER RICHARDS, JR. / STEWART F. RICHARDS				2. DATE OF DEATH (Month, Day, Year) 12 31 89	3. TIME OF DEATH 11:15 AM
4. SOCIAL SECURITY NUMBER 216-32-4580	5. SEX 1 X M 2 ☐ F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 12, 1901	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Greater Laurel-Beltsville Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Laurel		9c. COUNTY OF DEATH Prince George's

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Tracys Landing	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER 524 Arkhaven Avenue		10f. ZIP CODE 20779	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 7th; College (1-4 or 5+): --------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plumber	16b. KIND OF BUSINESS/INDUSTRY Self employed	
17. FATHER'S NAME (First, Middle, Last) Stewart F. Richards, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen V. Schriner	
19a. INFORMANT'S NAME (Type/Print) Dorothy M. ReinoelH	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 524 Arkhaven Ave., Tracys Landing, Md. 20779		
20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery	20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jack D'Friend	22. NAME AND ADDRESS OF FACILITY FRANCIS GASCH'S SONS FUNERAL HOME, 4739 Balt. Ave., Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. BACTERIA PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. SEPSIS, URINARY	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ORGANIC BRAIN SYNDROME	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D25422	▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. MAGIN, MD LAUREL, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 '90	Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

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89 37535

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET MARY SCHULLER

2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 89

3. TIME OF DEATH: 310 A M

4. SOCIAL SECURITY NUMBER: 579-26-9923

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): MAY 27, 1922

8. BIRTHPLACE (State or Foreign Country): Washington D.C.

9a. FACILITY NAME (If not institution, give street and number): 2204 DEXTER AVE,

9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING

9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND

10b. COUNTY: MONTGOMERY

10c. CITY, TOWN OR LOCATION: SILVER SPRING

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 2204 DEXTER AVE

10f. ZIP CODE: 20902

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES X

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: X

14. RACE — American Indian, Black, White, etc.
Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5+): 1 YEAR

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): FRED COE

18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET MARY WATHAN

19a. INFORMANT'S NAME (Type/Print): MICHAEL SCHULLER

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2204 DEXTER AVE. SIL. SPR. MD 20902

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) X

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): METROPOLITAN CREMTORY

20c. LOCATION — City or Town, State: ALEXANDRIA, VIRGINIA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Byler

22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL? SPR., MD. 20901

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma colon with diffuse metastasis — 1 yr

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: D Sengstack MD / Ed Richards MD

29c. LICENSE NUMBER: D12121

29d. DATE SIGNED (Month, Day, Year): ▶ 12-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 3929 FERRARA DR. WHEATON, MD. 20906 GEORGE F. SENGSTACK

31. DATE FILED (Month, Day, Year): JAN 3 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 [illegible] the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37536

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 must be attached to the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 must be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BEN SOMERS			2. DATE OF DEATH (Month, Day, Year): 12 21 89	3. TIME OF DEATH: 606 A M
4. SOCIAL SECURITY NUMBER: 110-28-2273	5. SEX: 1 ☒ M 2 ☐ F XX	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): SEPT 12, 1901	8. BIRTHPLACE (State or Foreign Country): RUSSIA
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: ROCKVILLE	10d. INSIDE CITY LIMITS? 1 ☒ YES X 2 ☐ NO
10e. STREET AND NUMBER: 6105 MONTROSE RD		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced X	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES XX 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO X Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — — ; College (1-4 or 5+): — — —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MANUFACTURER	16b. KIND OF BUSINESS/INDUSTRY: CHILDRENS HATS	
17. FATHER'S NAME (First, Middle, Last): JACOB SOMERS		18. MOTHER'S NAME (First, Middle, Maiden Surname): DORA MERER	
19a. INFORMANT'S NAME (Type/Print): EVELYN BOISEN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1001 CHISWELL LANE: SILVER SPRING, MD 20901	
20a. METHOD OF DISPOSITION: XX 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): MT. HEBRON	20c. LOCATION — City or Town, State: FLUSHINGS, NEW YORK
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Michael Berger		22. NAME AND ADDRESS OF FACILITY: DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE: ROCKVILLE, MD 20852	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	3 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	1 year Stroke
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. —	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. —	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. —

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ivan Paul Kreitzig MD	29c. LICENSE NUMBER: D21435	29d. DATE SIGNED (Month, Day, Year): ▶ 12-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, print): Ivan Paul Kreitzig 2101 Medical Park Dr Silver Spring, MD 20902		
31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau	

DHMH-16 Rev 1/89

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UNKNOWN #89-248

89 37537

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID W. SHORT			2. DATE OF DEATH (Month / Day / Year): 12 / 26 / 89	3. TIME OF DEATH: 8:44 P M
4. SOCIAL SECURITY NUMBER: 577 90 3007	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 23 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 10/21/667	8. BIRTHPLACE (State or Foreign Country): WASH.D.C.
9a. FACILITY NAME (If not institution, give street and number): Prince George's General		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: Prince George's	

RESIDENCE OF DECEDENT

10a. STATE: D.C.	10b. COUNTY: N/A	10c. CITY, TOWN OR LOCATION: WASHINGTON, D.C.	10d. INSIDE CITY LIMITS? XX 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 3060 STANTON ROAD, S.E.		10f. ZIP CODE: 20020	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER	15b. KIND OF BUSINESS/INDUSTRY: MOVING

17. FATHER'S NAME (First, Middle, Last): DAVID W. SHORT	18. MOTHER'S NAME (First, Middle, Maiden Surname): PATRICIA JONES
19a. INFORMANT'S NAME (Type/Print): ANTOINETTE JONES	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1720 27th STREET S.E. # 202 D.C. 20020

20a. METHOD OF DISPOSITION: 1 XX Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): LINCOLN MEMORIAL	20c. LOCATION — City or Town, State: SUITLAND, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ralph E. Williams	22. NAME AND ADDRESS OF FACILITY: RALPH WILLIAMS FUNERAL SERVICE 719 KENNEDY STREET N.W. 20011	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple gunshot wounds to head	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-26-89	28b. TIME OF INJURY: 8:15p M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject was shot
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): street			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 15 Opossim Ct., District Hgts, Md.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 12-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D.-Assistant 111 Penn Street BAltimore, MD 21201

31. DATE FILED (Month, Day, Year): JAN 05 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 may be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

89 37538

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sara B. Stiefel				2. DATE OF DEATH (Month / Day / Year): 12 / 21 / 89			3. TIME OF DEATH: 9:20 AM
4. SOCIAL SECURITY NUMBER: 236-56-7565	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 06-22-07		8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park, Maryland			9c. COUNTY OF DEATH: Montgomery		

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	MONTGOMERY	BETHESDA	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4890 BATTERY LANE #302	20814	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATE: X	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12): 12	College (1-4 or 5+):	SECRETARY	U.S. GOVERMENT

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
JACOB BORSTEIN	ANNA CAPLAN

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
HERBERT STIEFEL	4890 BATTERY LANE #302 :BETHESDA,MARYLAND 20814

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	KING DAVID MEMORIAL GARDEN	FALLS CHURCH,VA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Michael Kruger	DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE:ROCKVILLE,MD 20852

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aortic Stenosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Left Ventricular Hyper trophy

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Arthur W. Tulley MD, FACC FCCP	25136 (md)	▶ 12/21/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 11251 Lockwood Drive, Silver Spring, Maryland 20901

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	[illegible] Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. The certificate must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Copies 1, 2, 3 and 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal from the State.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37539

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed before the record or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILBUR SHARP / Wilbur Sharp			2. DATE OF DEATH (Month, Day, Year): 12 30 89	3. TIME OF DEATH: 0840 AM
4. SOCIAL SECURITY NUMBER: 217-10-8233	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-12-1916	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Dorchester General		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 424 Charles St.		10f. ZIP CODE: 21613		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Wilbert Sharp			18. MOTHER'S NAME (First, Middle, Maiden Surname): Evelyn Sharp	
19a. INFORMANT'S NAME (Type/Print): Barbara Harris		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 812 Bradley Ave, Cambridge, MD 21613		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery		20c. LOCATION — City or Town, State: Hurlock, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L Smith		22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services PO Box 928 Hurlock, MD 21643		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — REFRACTORY VENTRICULAR FIBRILLATION

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Refractory Ventricular Fibrillation

DUE TO (OR AS A CONSEQUENCE OF): MYCARDIAL INFRACTION

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF): COPD

c. COPD

DUE TO (OR AS A CONSEQUENCE OF): RECENT HYPOTHERMIA

d. Recent Hypothermia

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. — Alcoholism ALCOHOLISM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael Faulkner MD	29c. LICENSE NUMBER: D26388	29d. DATE SIGNED (Month, Day, Year) ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael J Faulkner MD 302 Collins Hurlock Md 21643		
31. DATE FILED (Month, Day, Year): JAN - 9 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMN-16 Rev 1/89

89 37540

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT B. SMITH			2. DATE OF DEATH (Month, Day, Year): DECEMBER 28, 1989	3. TIME OF DEATH: 8A M
4. SOCIAL SECURITY NUMBER: 216-12-6657	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT. 2, 1923	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 2409 WOOD STREAM COURT		9b. CITY, TOWN OR LOCATION OF DEATH: ELLICOTT CITY	9c. COUNTY OF DEATH: HOWARD	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: HOWARD	10c. CITY, TOWN OR LOCATION: ELLICOTT CITY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 2409 WOOD STREAM COURT		10f. ZIP CODE: 21043	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SUPERVISOR	16b. KIND OF BUSINESS/INDUSTRY: UNIROYAL TIRE CO.	
17. FATHER'S NAME (First, Middle, Last): HARRY W. SMITH		18. MOTHER'S NAME (First, Middle, Maiden Surname): NELLIE M. BARNES	
19a. INFORMANT'S NAME (Type/Print): CHARLENE MOWERY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2409 WOOD STREAM COURT, ELLICOTT CITY, MD. 21043	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CRESTLAWN CEMETERY	20c. LOCATION — City or Town, State: MARRIOTTSVILLE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leroy M. & Russell C. Witzke		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Carcinoma of the Pancreas	months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Parkinsons Disease, severe

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James J. Nolan MD	29c. LICENSE NUMBER: D07243	29d. DATE SIGNED (Month, Day, Year): 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES NOLAN M.D. 1 MALLOW HILL ROAD, BALTIMORE, MARYLAND 21228		
31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-15 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

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89 37541

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Herman Eured Seal			2. DATE OF DEATH (Month, Day, Year): 12-31-89	3. TIME OF DEATH: 11:00 pM
4. SOCIAL SECURITY NUMBER: 214-12-7280	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-08-1919	8. BIRTHPLACE (State or Foreign Country): Tennessee
9a. FACILITY NAME (If not institution, give street and number): 3092 D Rogers Ave.		9b. CITY, TOWN OR LOCATION OF DEATH: ELlicott City		9c. COUNTY OF DEATH: Howard
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Ellicott City		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3092 D Rogers Ave.		10f. ZIP CODE: 21043		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Research	16b. KIND OF BUSINESS/INDUSTRY: W.R. GRace		
17. FATHER'S NAME (First, Middle, Last): Alonzo Seal		18. MOTHER'S NAME (First, Middle, Maiden Surname): Tressi Turner		
19a. INFORMANT'S NAME (Type/Print): Margaret Seal		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3092 D Rogers Ave. Ellicott City, Md. 21043		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Seal Family Cemetery	20c. LOCATION — City or Town, State: Sneedsville, Tenn.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Allen Slack 535 mod	22. NAME AND ADDRESS OF FACILITY: Slack Funeral Home POBox 268, Ellicott City, Md. 21043			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma of colon	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. with liver metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: cirrhosis of liver; hypertension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Barahona	29c. LICENSE NUMBER: D21928	29d. DATE SIGNED (Month, Day, Year): ▶ 1/2/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Leonel Barahona, M.D., 1101 Maiden Choice Ln. Balto. MD 21229		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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DHMH-1S Rev 1/89

89 37542

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Fannie Main Smith

2. DATE OF DEATH (Month, Day, Year): Dec. 30, 1989

3. TIME OF DEATH: 2:00 A. M

4. SOCIAL SECURITY NUMBER: 213-74-8039

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 88 YRS.
IF UNDER 1 YEAR — MONTHS / DAYS; IF UNDER 24 HRS. — HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): July 5, 1901

8. BIRTHPLACE (State or Foreign Country): Scotland

9a. FACILITY NAME (If not institution, give street and number): 106 W. Main St.

9b. CITY, TOWN OR LOCATION OF DEATH: Lonaconing

9c. COUNTY OF DEATH: Allegany

RESIDENCE OF DECEDENT

10a. STATE: Md

10b. COUNTY: Allegany

10c. CITY, TOWN OR LOCATION: Lonaconing

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 106 W. Main St.

10f. ZIP CODE: 21539

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 7
College (1-4 or 5 +): 0

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker

16b. KIND OF BUSINESS/INDUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): Wm. Main

18. MOTHER'S NAME (First, Middle, Maiden Surname): Martha Bartholomew

19a. INFORMANT'S NAME (Type/Print): Betty J. Smith

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 106 W. Main St., Lonaconing, Md. 21539

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frostburg Memorial Park

20c. LOCATION — City or Town, State: Frostburg, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Jane E McKe

22. NAME AND ADDRESS OF FACILITY: Eichhorn-McKenzie Funeral Home
Lonaconing, Md. 21539

TO BE COMPLETED BY PHYSICIAN; MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multi strokes	
DUE TO (OR AS A CONSEQUENCE OF):	b. AsVD	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
UTI
Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: H C Merrick

29c. LICENSE NUMBER: D28910

29d. DATE SIGNED (Month, Day, Year): ▶ 1-4-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): H. C. Merrick 500 Memorial Ave., Cumberland, Md. 21502

31. DATE FILED (Month, Day, Year): JAN 08 1990

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37543

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IVAN D. STEWART			2. DATE OF DEATH (Month, Day, Year): Dec. 27, 1989	3. TIME OF DEATH: 7-30P. M
4. SOCIAL SECURITY NUMBER: 256-54-9359	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 27, 1933	8. BIRTHPLACE (State or Foreign Country): Oregon
9a. FACILITY NAME (If not institution, give street and number): Washington Co. Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Pa.	10b. COUNTY: Franklin	10c. CITY, TOWN OR LOCATION: 14411 Ft. Loudon Rd., Mercersburg Pa. 17236	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 14411 Ft. Loudon Rd.		10f. ZIP CODE: 17236	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Korean Conflict	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Purchasin Agent	16b. KIND OF BUSINESS/INDUSTRY: Machine Shop	
17. FATHER'S NAME (First, Middle, Last): William Stewart		18. MOTHER'S NAME (First, Middle, Maiden Surname): Velma Margaret Keithley	
19a. INFORMANT'S NAME (Type/Print): Velma F. Stewart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14411 Ft. Loudon Rd., Mercersburg, Pa. 17236	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fairview Cemetery	20c. LOCATION — City or Town, State: Mercersburg, Franklin Co., Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. M. Lininger		22. NAME AND ADDRESS OF FACILITY: Lininger-Fries Funeral Home 47 N. Park Ave., Mercersburg, Pa. 17236	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Atherosclerotic cardiovascular disease.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cardiomyopathy · S/P. cardiac transplant; renal insuffiency

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George Newman II M.D. Ph.D.	29c. LICENSE NUMBER: D 17591	29d. DATE SIGNED (Month, Day, Year): ▶ 1/5/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George Newman II 1825 Howell Rd., Hagerstown, Md. 21740		
31. DATE FILED (Month, Day, Year): JAN 12 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

DHMN-16 Rev 1/89

Original certificate lost in Hosp. during Holidays.

89 37544

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MAUDE P. SCHUSTER
2. DATE OF DEATH (Month, Day, Year): DEC 25 1989
3. TIME OF DEATH: 1:00 PM
4. SOCIAL SECURITY NUMBER: 577-07-0182
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 17, 1905
8. BIRTHPLACE (State or Foreign Country): Wash. D.C.
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Beltsville
9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: College Park
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4903 Hollywood Rd.
10f. ZIP CODE: 20740
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): ------
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): George Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN
19a. INFORMANT'S NAME (Type/Print): Alfred Schuster
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4903 Hollywood Rd. College Park, MD. 20740
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Chambers Crematory
20c. LOCATION — City or Town, State: Riverdale, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers #1670
22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter tha mode of dying, such as cardiac or respiratory srrest, shock, or heart failure. List only one cause on asch line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARRYTHMIA	
	DUE TO (OR AS A CONSEQUENCE OF): Cardiac arrythmia	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ~~ORGANIC~~ ~~BRAIN~~ ~~SYNDROME~~

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
26a. DATE OF INJURY (Month, Day, Year)
26b. TIME OF INJURY
26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
26d. DESCRIBE HOW INJURY OCCURED
26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D25430
29d. DATE SIGNED (Month, Day, Year): 12/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 23 (Type, Print): JOHN HARGOVIS 14333 Laurel Bowie Rd #307, LAUREL, MD. 20708
31. DATE FILED (Month, Day, Year): DEC 27 89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37545

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MONA BEATRICE SHULTZ			2. DATE OF DEATH (Month, Day, Year): 12 24 1989	3. TIME OF DEATH: 1036 A M
4. SOCIAL SECURITY NUMBER: 366-18-3737	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-22-1911	8. BIRTHPLACE (State or Foreign Country): ENGLAND
9a. FACILITY NAME (If not institution, give street and number): SHADY GROVE ADVENTIST HOSP		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: SILVER SPRING	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2815 VIXEN LANE		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): FREDERICK HUTCHINGS		18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZA BENNETT	
19a. INFORMANT'S NAME (Type/Print): ROBERT R. SHULTZ SON		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 125 CHESTNUT AVE. WASHINGTON GROVE, MARYLAND 20880	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARKLAWN CEMETERY	20c. LOCATION — City or Town, State: ROCKVILLE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Steven D Brand		22. NAME AND ADDRESS OF FACILITY: FRANCIS J. COLLINS FUNERAL HOME, INC. 500 UNIVERSITY BLVD., W. SIL. SPR., MD. 20901	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Septicemia	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF):	c. Cerebrovascular Accident	
	d. Alzheimers Disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: S. Abulfaraj	29c. LICENSE NUMBER: 31391	29d. DATE SIGNED (Month, Day, Year): ▶ 12/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): S. Abulfaraj - 19261 Montgomery Village Ave. G'burg - G'lo		
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

12

DHMH-18 Rev 1/89

89 37546

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HERBERT SELL			2. DATE OF DEATH MONTH 12 DAY 23 YEAR 89	3. TIME OF DEATH 0537 AM
4. SOCIAL SECURITY NUMBER: 130-14-2716	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-06-04	8. BIRTHPLACE (State or Foreign Country): GERMANY
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hosp		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING	9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: BETHESDA	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5101 River Road	10f. ZIP CODE: 20816	10g. CITIZEN OF WHAT COUNTRY? USA.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Self Employed	16b. KIND OF BUSINESS/INDUSTRY: Electrical	
17. FATHER'S NAME (First, Middle, Last): Bernard Sellgmann		18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Straus	
19a. INFORMANT'S NAME (Type/Print): Alice C. Sell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5101 River Road Bethesda, Maryland 20816	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Comfort Crematory	20c. LOCATION — City or Town, State: Alexandria, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith L. Gawler		22. NAME AND ADDRESS OF FACILITY: JOSEPH GAWLER'S SONS 5130 Wisconsin Avenue, NW Washington, DC 20016	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac - Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Acute Myocardial Infarction
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
acute Cholecystitis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Kramer MD	29c. LICENSE NUMBER: D0 5927	29d. DATE SIGNED (Month, Day, Year) ▶ 12-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT KRAMER MD 10313 Georgia Ave Silver Spring, Md 20902		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37547

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY H SHERROD
2. DATE OF DEATH: MONTH 12 DAY 9 YEAR 89
3. TIME OF DEATH: 4:15 AM
4. SOCIAL SECURITY NUMBER: Unknown
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 7/10/29
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Clinton
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Woldorf
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 808 Kirkland Road
10f. ZIP CODE: 20601
10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11th grade; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse
16b. KIND OF BUSINESS/INDUSTRY: N/A
17. FATHER'S NAME (First, Middle, Last): David Worsley
18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy Lewis
19a. INFORMANT'S NAME (Type/Print): Carroll Sherrod
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 808 Kirkland Road, Waldorf, Maryland 20601
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hamilton Gardens
20c. LOCATION — City or Town, State: Wilson, North Carolina
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W.H. Bacon
22. NAME AND ADDRESS OF FACILITY: W.H. Bacon Funeral Home 3447 14th Street, N.W. Wash,DC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIO RESPIRATORY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. PANCREATITIS

DUE TO (OR AS A CONSEQUENCE OF):

c. UPPER GI BLEEDING

DUE TO (OR AS A CONSEQUENCE OF):

d. SEPSIS

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC RENAL FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 12/11/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. Gonsalves 7503 Surratts Road Clinton, Maryland 20735

31. DATE FILED (Month, Day, Year): JAN 04 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37548

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony Siderchuck			2. DATE OF DEATH (Month / Day / Year): 12 / 27 / 89	3. TIME OF DEATH: 0900 M
4. SOCIAL SECURITY NUMBER: 215-12-1275	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 02-02-23	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 123 Ridgefield, Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Fruitland		9c. COUNTY OF DEATH: Wicomico
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Fruitland		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 123 Ridgefield Drive		10f. ZIP CODE: 21826		10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: War 2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Road Construction		16b. KIND OF BUSINESS/INDUSTRY: Pile Driver
17. FATHER'S NAME (First, Middle, Last): Dominic Siderchuch		18. MOTHER'S NAME (First, Middle, Maiden Surname): Irena Zarko		
19a. INFORMANT'S NAME (Type/Print): Shirley Siderchuck		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 123 Ridgefield Dr. Fruitland, Md. 21826		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Springhill Memory Gardens	20c. LOCATION — City or Town, State: Hebron, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hinman		22. NAME AND ADDRESS OF FACILITY: Hinman Funeral Home 127 Somerset Ave., Princess Anne, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Lung Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John T. Bulkeley Deputy M.E.	D03599	▶ 12-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John T. Bulkeley, M.D. - Salisbury, Maryland

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 28 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37549

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)			3. TIME OF DEATH
[illegible] DENZIL	GENE	SHILLINGBURG	12	27	89	8:18P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
			MONTHS	DAYS	HOURS	MIN.		
220-28-7649	1 [X] M 2 [ ] F	59 YRS.					Apr. 9, 1930	West Virginia

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
702 Ludlow St.	Takoma Park	Montgomery

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Montgomery	Takoma Park	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
702 Ludlow Street	20912	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO — Korea & Viet Nam	1 [ ] YES 2 [X] NO — Specify:	Specify: White

15. DECEOENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12th		Laborer	Construction

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Roy Shillingburg	Ida Mae Mosser

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Viola M. McWilliams	Rt. 1, Box 346, Aurora, West Virginia 26705

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Omega Crematory	Morgantown, West Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Bradley K. Stewart	Stewart Funeral Home 32 S. Second St., Oakland, MD 21550

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute and chronic alcohol abuse	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 12-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

James A. Kaplan, M.D.-Assistant 111 Penn St., Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 03 '90	[signature]

4

DHMH-16 Rev 1/89

89 37550

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERNEST R SUHR / ERNest R SuHR
2. DATE OF DEATH (Month, Day, Year): 12 22 89
3. TIME OF DEATH: 04.10 AM
4. SOCIAL SECURITY NUMBER: 213- 24-4666 / 213 24 4666
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 / 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2 2 20 25
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL / Dorchester Gen. Hosp.
9b. CITY, TOWN OR LOCATION OF DEATH: CAMBRIDGE / Cambridge md
9c. COUNTY OF DEATH: DORCHESTER / Dorchester

RESIDENCE OF DECEDENT

10a. STATE: MD / Md.
10b. COUNTY: DORCHESTER / Dorchester
10c. CITY, TOWN OR LOCATION: EAST NEW MARKET / East New Market
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [XX] NO
10e. STREET AND NUMBER: ROUTE 1, BOX 56-THOMPSONTOWN ROAD / Rt 1 Box 56
10f. ZIP CODE: 21631 / 21631
10g. CITIZEN OF WHAT COUNTRY: USA / USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [XX] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [XX] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE / White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DEPT. OF HUMAN RESOUCES
16b. KIND OF BUSINESS/INDUSTRY: STATE OF MARYLAND
17. FATHER'S NAME (First, Middle, Last): AUGUST F. SUHR
16. MOTHER'S NAME (First, Middle, Maiden Surname): LOUISE CLAUSSER
19a. INFORMANT'S NAME (Type/Print): BERNICE CLAUSSER
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX 4, EAST NEW MARKET, MD 21631
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EAST NEW MARKET CEMETERY
20c. LOCATION — City or Town, State: EAST NEW MARKET, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard Zeller
22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME / EAST NEW MARKET, MD 21631

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction / Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Jay Harper M.D.
29c. LICENSE NUMBER: D02724
29d. DATE SIGNED (Month, Day, Year): 12/22/89 / 12-22-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jay Harper Cambridge, Md. 21613 / Jay Harper Cambridge, Md. 21613
31. DATE FILED (Month, Day, Year): JAN 4 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. [illegible] should be detached by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37550

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89 37551

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Walter E. SELLERS			2. DATE OF DEATH (Month, Day, Year): 12 29 89	3. TIME OF DEATH: 12:03 P M
4. SOCIAL SECURITY NUMBER: 226-01-2092	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 09/14/01	8. BIRTHPLACE (State or Foreign Country): Virginia

9a. FACILITY NAME (If not institution, give street and number): AMI DRS' HOSPITAL OF P. G. COUNTY	9b. CITY, TOWN OR LOCATION OF DEATH: Lanham	9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Virginia	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Eagle Rock	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: RFD #2		10f. ZIP CODE: 24085	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWI	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machine Operator	16b. KIND OF BUSINESS/INDUSTRY: Chemical Plant	
17. FATHER'S NAME (First, Middle, Last): Francis A. Sellers		18. MOTHER'S NAME (First, Middle, Maiden Surname): Cora Kelley	
19a. INFORMANT'S NAME (Type/Print): Eagle Rock Funeral Home	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 56 Eagle Rock, Virginia 24085		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Grove Cemetery	20c. LOCATION — City or Town, State: Eagle Rock, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac arrest	1 hr.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Coronary Artery Disease	5 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Arteriosclerosis	10 yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Vascular disease of legs

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jack C Meshel MD	29c. LICENSE NUMBER: D08164	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JACK C Meshel MD. 3311 Toledo Ter. Suite 101 Hyattsville MD 20782		
31. DATE RECEIVED (Month, Day, Year): JAN 03 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

89 37552

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Emily Lacey SKILLMAN			2. DATE OF DEATH (Month, Day, Year): 12-31-89	3. TIME OF DEATH: 5:25AM M
4. SOCIAL SECURITY NUMBER: Infant	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 0 YRS. (If under 1 year: Months 0 Days 0; If under 24 hrs.: Hours 6 Min. 55)	7. DATE OF BIRTH (Month, Day, Year): 12-30-89	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospial Center		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Harford	10c. CITY, TOWN OR LOCATION: Belcamp		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1274 Collier Lane		10f. ZIP CODE: 21017		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuben, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — Americen Indien, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Infant; College (1-4 or 5+): Infant		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Infant		16b. KIND OF BUSINESS/INDUSTRY: Infant
17. FATHER'S NAME (First, Middle, Last): Robert Carl Skillman			18. MOTHER'S NAME (First, Middle, Maiden Surname): Deborah Jacqueline Lacey	
19a. INFORMANT'S NAME (Type/Print): Robert C. Skillman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1274 Collier Lane, Belcamp, Md. 21017		
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Highview Memorial Gardens		20c. LOCATION — City or Town, State: Fallston, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Howard K McComas III		22. NAME AND ADDRESS OF FACILITY: Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiorespiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Severe Prematurity
DUE TO (OR AS A CONSEQUENCE OF):
c. Hyaline Membrane Disease
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Bilateral Pneumothorsces

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Salvador Papa

29c. LICENSE NUMBER: D27002

29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Salvador Papa 9000 Franklin Square Drive Baltimore, Md 21237

31. DATE FILED (Month, Day, Year): JAN 08 '90

32. REGISTRAR'S SIGNATURE: Gaha Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37553

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BLAIR B. STALLINGS
2. DATE OF DEATH (Month, Day, Year): 12 26 89
3. TIME OF DEATH: 1100 AM
4. SOCIAL SECURITY NUMBER: 220-36-9891
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 76 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)
7. DATE OF BIRTH (Month, Day, Year): Feb. 5, 1913
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 11109 Old Marlboro Pike
9b. CITY, TOWN OR LOCATION OF DEATH: Upper Marlboro
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Pr. Georges's
10c. CITY, TOWN OR LOCATION: Upper Marlboro
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 11109 Old Marlboro Pike
10f. ZIP CODE: 20772
10g. CITIZEN OF WHAT COUNTRY?: U. S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (11); College (1-4 or 5+): None
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Supervisor
16b. KIND OF BUSINESS/INDUSTRY: State Roads Commission
17. FATHER'S NAME (First, Middle, Last): Richard Thomas Stallings
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Mae Beall
19a. INFORMANT'S NAME (Type/Print): Frank Jenkins
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11109 Old Marlboro Pike, Upper Marlboro, Md. 20772
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Epiphany Cemetery
20c. LOCATION — City or Town, State: Forestville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard A. Coleman
22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home, Upper Marlboro, Maryland 20772

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	ACUTE HYPERCALCEMIA	1 WEEK
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	LUNG CARCINOMA	8 MONTHS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CARCINOMA METASTATIC TO BONE
SPINAL CORD COMPRESSION
ISCHEMIC CORONARY ARTERY DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michael York MD
29c. LICENSE NUMBER: D28494
29d. DATE SIGNED (Month, Day, Year): 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL YORK MD (627 3370) 5506 GREEN LANDING RD. UPPER MARLBORO MD 20772
31. DATE FILED (Month, Day, Year): JAN 09 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 37554

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is restored by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Boyd Tyler (NMN) TYLER			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89		3. TIME OF DEATH: 12:30 A M
4. SOCIAL SECURITY NUMBER: 214-30-4285	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 03-13-33
8. BIRTHPLACE (State or Foreign Country): Maryland					
8a. FACILITY NAME (If not institution, give street and number): Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Columbia			9c. COUNTY OF DEATH: Howard

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Columbia	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 10530 Cross Fox Lane, #A-2		10f. ZIP CODE: 21044	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Heavy Equip. Truck driver/ operator	16b. KIND OF BUSINESS/INDUSTRY: Sand & Gravel Company	
17. FATHER'S NAME (First, Middle, Last): Harry Edward Tyler		18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Ellen Fetzer	
19a. INFORMANT'S NAME (Type/Print): Katherine E. Tyler	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10530 Cross Fox Lane, #A-2 Columbia, Md. 21044		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. John's Episcopal Church Cem.	20c. LOCATION — City or Town, State: Beltsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: FRANCIS GASCH'S SONS FUNERAL HOME 4739 Balt. Ave., Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Asthma	50 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Renal Failure	5 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Biventricular Heart failure	5 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard W. Smith MD	29c. LICENSE NUMBER: D25578	29d. DATE SIGNED (Month, Day, Year): ▶ 12-28-89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard W. Smith MD. 10507 Hickory Ridge Rd. Columbia MD. 21044		
31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37555

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be detached by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Earl Addison TALBERT		2. DATE OF DEATH (Month, Day, Year): December 24, 1989	3. TIME OF DEATH: 9:02 P M
4. SOCIAL SECURITY NUMBER: 214-12-7379	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 7. 1923
8. BIRTHPLACE (State or Foreign Country): Washington, DC			
9a. FACILITY NAME (If not institution, give street and number): Doctor's Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Lanham	9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Hyattsville	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 7407 Parkwood Street	10f. ZIP CODE: 20784	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th Grade; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Thomas G. Talbert	18. MOTHER'S NAME (First, Middle, Maiden Surname): Naomie M. Ziegler		
19a. INFORMANT'S NAME (Type/Print): Louise V. Talbert (Wife)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7407 Parkwood Street, Hyattsville, Maryland 20784		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Jack D Friend	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory Failure - Chronic	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Obstruction of Hypopharynx & oropharynx by Radiation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Aspiration Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Carcinoma of the Epiglottis.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD		12/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4410 74th Ave Landover Hills MD 20784

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Julia Davidson-Randall

(16) (NA)

DHMH-16 Rev 1/89

Item # 1, per Court Order,Film # G746, 4/4/97,gap

89 37556

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~JOAQUIN A. TORRES~~ ~~Joaquin A Torres~~ Joaquin Antonio Torres

2. DATE OF DEATH: MONTH 12 DAY 22 YEAR 89

3. TIME OF DEATH: 8:20 M

4. SOCIAL SECURITY NUMBER: 578-80-1363

5. SEX: 1 X M 2 ☐ F

6. AGE (If under 1 year or 1 day old, last birthday): 60 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 05-11-29

8. BIRTHPLACE (State or Foreign Country): ARGENTINA Argentina

9a. FACILITY NAME (If not institution, give street and number): SUBURBAN HOSPITAL Suburban Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: BETHESDA Bethesda

9c. COUNTY OF DEATH: MONTGOMERY Montgomery

RESIDENCE OF DECEDENT

10a. STATE: DC

10b. COUNTY: NONE

10c. CITY, TOWN OR LOCATION: WASHINGTON

10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO

10e. STREET AND NUMBER: 1333 IVES PLACE S. E.

10f. ZIP CODE: 20003

10g. CITIZEN OF WHAT COUNTRY? Argentina

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X YES 2 ☐ NO Specify: ARGENTINE Argentine

14. RACE — American Indian, Black, White, etc. Specify: WHITE white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+): 5+

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): ENGINEER

16b. KIND OF BUSINESS/INDUSTRY: TECHNICAL

17. FATHER'S NAME (First, Middle, Last): JOAQUIN A. TORRES SR.

18. MOTHER'S NAME (First, Middle, Maiden Surname): CATHALINA ALVAREZ

19a. INFORMANT'S NAME (Type/Print): GUILLERMO BANDZEREWICZ

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1333 IVES PL. S.E., WASHINGTON, D.C. 20003

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHAMBERS CREMATORY

20c. LOCATION — City or Town, State: RIVERDALE, MD.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W.W. Chambers MO0091

22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. 517 11th ST. S.E., WASH.,D.C.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ~~24~~ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY EDEMA Pulmonary edema — 20 Hrs

DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE CARDIOMYOPATHY

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Congestive Cardiomyopathy — 2 YEARS

DUE TO (OR AS A CONSEQUENCE OF): CORONARY HEART DIS.

c. CORONARY Heart disease — 10 YEARS

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 X DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Luis Bentolila MD

29c. LICENSE NUMBER: D02513

29d. DATE SIGNED (Month, Day, Year): 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LUIS F. BENTOLILA MD 4343 MONTGOMERY AVE., BETHESDA, MD 20814
LUIS F. BENTOLILA MD 4343 MONTGOMERY Ave Bethesda MD 20814

31. DATE FILED (Month, Day, Year): DEC 27 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

RELEASED 134 DR MAYLE

2

89 37557

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCES L. CHACONAS VANECH				2. DATE OF DEATH: MONTH 12 DAY 30 YEAR 89 (12-30-89)	3. TIME OF DEATH: 9:35 PM M
4. SOCIAL SECURITY NUMBER: 578-44-5779	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): January 11, 1924	8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Washington Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 548 Southampton Dr.		10f. ZIP CODE: 20903			10g. CITIZEN OF WHAT COUNTRY?: U. S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary		16b. KIND OF BUSINESS/INDUSTRY: U. S. Government	
17. FATHER'S NAME (First, Middle, Last): Louis Chaconas		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Skiados			
19a. INFORMANT'S NAME (Type/Print): Nicholas H. Vanech		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 548 Southampton Dr., Silver Spring, MD 20903			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery		20c. LOCATION — City or Town, State: Arlington, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael E. Nelson		22. NAME AND ADDRESS OF FACILITY: Joseph Gawler's Sons, 5130 Wisconsin AV., Washington, DC 20016			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO-RESPIRATORY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASPIRATION / HYPOXIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. BREAST CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO (Refused)

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): 12-30-89 | 28b. TIME OF INJURY: 2 PM M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO | 28d. DESCRIBE HOW INJURY OCCURED: —

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D30769

29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RAKESH SAHNI, WAH, TAKOMA PARK, MD 20012

31. DATE FILED (Month, Day, Year): JAN 3 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMH-16 Rev 1/89

6

89 37558

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): IDA A. WILSON			2. DATE OF DEATH Month/Day/Year: 12-31-1989	3. TIME OF DEATH: 6:00 A.M
4. SOCIAL SECURITY NUMBER: 214-01-0836	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 95 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8/22/1894	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): NATIONAL LUTHERAN HOME		9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5462 Frederick Avenue		10f. ZIP CODE: 21229		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress		16b. KIND OF BUSINESS/INDUSTRY: unknown
17. FATHER'S NAME (First, Middle, Last): John Karl Domeika		18. MOTHER'S NAME (First, Middle, Maiden Surname): Julia Juehn		
19a. INFORMANT'S NAME (Type/Print): Rev.Dr.Richard Reichard		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9701 Veirs Dr.Rockville, Md. 20850		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lorraine Park Mausoleum		20c. LOCATION — City or Town, State: Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: William Hysong		22. NAME AND ADDRESS OF FACILITY: Hysong Company, Inc. 1300 N Street, N.W. Wash.D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio respiratory Arrest	—
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Arteriosclerotic Heart Disease	24 Hrs
	OUE TO (OR AS A CONSEQUENCE OF):	
	c. Arteriosclerotic Heart Disease	Many Yrs
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Edward J Dwin	D33677	12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward J Dwin MD 19721 Executive Park Circle Germantown MD 20874

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 8 '90	Julia Davidson Randall

DHMH-16 Rev 1/89

89 37559

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Russell Clinton Ward		2. DATE OF DEATH (Month, Day, Year): Dec 30 1989	3. TIME OF DEATH: 10:30 am
4. SOCIAL SECURITY NUMBER: 218 - 44 - 5700	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 42 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): May 13, 1947
8. BIRTHPLACE (State or Foreign Country): West Virginia			
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel-Beltsville Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Laurel	9c. COUNTY OF DEATH: Prince George	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Savage	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8474 Savage-Guilford Road	10f. ZIP CODE: 20763	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Grade 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Millard Ward	18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Pruitt		
19a. INFORMANT'S NAME (Type/Print): Emma Ward	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8474 Savage-Guilford Road Savage, Maryland 20763		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Meadowridge Memorial Park	20c. LOCATION — City or Town, State: Dorsey, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: D. W. Donaldson F.D.	22. NAME AND ADDRESS OF FACILITY: Donaldson Funeral Home P.A. 313 Talbott Ave Laurel, Maryland 20707		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cancer of lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Martin O. Weltz	29c. LICENSE NUMBER: D23743	29d. DATE SIGNED (Month, Day, Year): 12 30 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MARTIN WELTZ 7525 Greenmead Dr Ow Greenbelt MD 20770		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37560

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald T. Williams				2. DATE OF DEATH (Month / Day / Year): 12 / 31 / 89	3. TIME OF DEATH: 4:45 p M
4. SOCIAL SECURITY NUMBER: 219-14-3703	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08/06/23	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Caroline		10c. CITY, TOWN OR LOCATION: Federalsburg		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: Rt. 1, Box 140			10f. ZIP CODE: 21632		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Service Technician		16b. KIND OF BUSINESS/INDUSTRY: Trucking	
17. FATHER'S NAME (First, Middle, Last): Gardner T. Williams			18. MOTHER'S NAME (First, Middle, Maiden Surname): Maude E. Trice Williams			
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy P. Williams			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1, Box 140, Federalsburg, MD 21632			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hill Crest Cemetery		20c. LOCATION — City or Town, State: Federalsburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Eskow			22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ACUTE INFERIOR MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):	4 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. VENTRICULAR TACHYCARDIA DUE TO (OR AS A CONSEQUENCE OF):	4 days
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. SEVERE CENTRAL NERVOUS SYSTEM INJURY 2° #A ABOVE	4 days

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ludwig J. Eglseder III MD

29c. LICENSE NUMBER: md D31466

29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ludwig J. Eglseder III MD, RT 3 Box 106 Enton md 21601

31. DATE FILED (Month, Day, Year): JAN - 4 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson Pondelle

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. ... the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral ... be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 37561

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Kathleen H. Wolford			2. DATE OF DEATH: MONTH 12/30/89 DAY YEAR	3. TIME OF DEATH: 630 A M
4. SOCIAL SECURITY NUMBER: 214-03-8640	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 3-21-97	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Summit Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville		9c. COUNTY OF DEATH: Baltimore

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Dayton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 14065 Triadelphia Rd		10f. ZIP CODE: 21036	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): -- Hawkins	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lila L. Roberts
19a. INFORMANT'S NAME (Type/Print): Jean Soloman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 117 Clarksville MD 21029

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metro Crematory	20c. LOCATION — City or Town, State: Catonsville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Harry H. Witzke	22. NAME AND ADDRESS OF FACILITY: Harry H Witzke Funeral Home 4112 Columbia Pike Ellicott City MD 21043	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic renal failure
Organic dementia

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James E Rowe MD	29c. LICENSE NUMBER: D13170	29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): V. E. Rowe Summit Nursing Home		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Jacke Davidson-Randall	

DHMH-16 Rev 1/89

89 37562

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Adele E. Wagner		2. DATE OF DEATH (Month, Day, Year): December 21, 1989	3. TIME OF DEATH: 7:51 P M
4. SOCIAL SECURITY NUMBER: 153 12 1248	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 7,1919
8. BIRTHPLACE (State or Foreign Country): New Jersey			
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Derwood	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 16109 Crabbs Branch Way Apt.#14	10f. ZIP CODE: 20855	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 8+): 0	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Legal Secretary	16b. KIND OF BUSINESS/INDUSTRY: State Government	
17. FATHER'S NAME (First, Middle, Last): Frederick J. Becht	18. MOTHER'S NAME (First, Middle, Maiden Surname): Beatrice Allen Grant		
19a. INFORMANT'S NAME (Type/Print): Richard F. Lindauer	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15825 Buena Vista Drive, Derwood, Maryland 20855		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Nelson Cemetery	20c. LOCATION — City or Town, State: Roan Mountain, Tn.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature] M00689	22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	VENTRICULAR FIBRILATION	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	CORONARY ARTERY DISERSE	2yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	ARTERIOSCLEROSIS	10 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
d.	DIABETES MELLITUS	20 yrs

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC RENAL FAILURE
HypoTHYROIDISM

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Herm Padilla MD	D-32-397	▶ 12-22-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Herman Padilla M.D. 501 North Frederick Avenue Gaithersburg, Maryland 20877

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	Julia Davidson Rudasill

DHMH-1a Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 or 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 37563

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANCIS H. WILDMAN			2. DATE OF DEATH: MONTH 12 DAY 22 YEAR 89	3. TIME OF DEATH: 2155 M
4. SOCIAL SECURITY NUMBER: 176-24-3876	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 9, 1925	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 5102 Parklawn Terrace #203		10f. ZIP CODE: 20852	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Transportation Executive	16b. KIND OF BUSINESS/INDUSTRY: Air/Motor Freight	
17. FATHER'S NAME (First, Middle, Last): Robert Lee Wildman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth Hogan		
19a. INFORMANT'S NAME (Type/Print): Eleanor S. Wildman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5102 Parklawn Terrace #203 Rockville, MD 20852		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery Crematorium, Inc.	20c. LOCATION — City or Town, State: Bethesda, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J. Aaron Dyer M00853		22. NAME AND ADDRESS OF FACILITY: Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave. 20850-2805		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. gastric atony	1 mo.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. pancreatic carcinoma	6 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

carcinoma of lung
Chronic obstructive lung disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jeremy V Cooke MD	29c. LICENSE NUMBER: D04602	29d. DATE SIGNED (Month, Day, Year): ▶ 1/12/23/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeremy V. Cooke 10400 Conn. Ave, Kensington Md		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

10

DHMH-16 Rev 1/89

89 37564

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ella Weissmueller				2. DATE OF DEATH: MONTH Dec. DAY 25 YEAR 1989	3. TIME OF DEATH: 6:10 PM
4. SOCIAL SECURITY NUMBER: 578-03-0010	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec/21/1906	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): National Lutheran Home			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 9701 Veirs Drive		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): cashier	16b. KIND OF BUSINESS/INDUSTRY: restaurant	
17. FATHER'S NAME (First, Middle, Last): Edward Schonrank		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Niederstrasser	
19a. INFORMANT'S NAME (Type/Print): Anna Schoenly	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8210 Jeb Stuart Road Rockville MD 20854		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Wilhelm	22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm Funeral Home, Inc. Suitland MD 20746		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebral CVA	Acute
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Thomas E. Dooley MD	D16458	▶ 12/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas E. Dooley, MD 17504 Georgia Ave Olney 20832

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 04 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37565

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permi
be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.
ges 1, 2, 3 should

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT W. WEST			2. DATE OF DEATH MONTH 12 DAY 29 YEAR 89	3. TIME OF DEATH 430 A M
4. SOCIAL SECURITY NUMBER: 511-09-6058	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs, last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/21/15	8. BIRTHPLACE (State or Foreign Country): KANSAS
9a. FACILITY NAME (If not institution, give street and number): Howard County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA		9c. COUNTY OF DEATH: HOWARD
RESIDENCE OF DECEDENT				
10a. STATE: KANSAS	10b. COUNTY: POTTAWATOMIC	10c. CITY, TOWN OR LOCATION: WAMEGO		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☑ NO
10e. STREET AND NUMBER: 600 CHESTNUT STREET		10f. ZIP CODE: 66547		10g. CITIZEN OF WHAT COUNTRY? US.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5 +): 5 yr	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CIVIL ENGINEER		16b. KIND OF BUSINESS/INDUSTRY: DEPARTMENT OF TRANSPORTATION
17. FATHER'S NAME (First, Middle, Last): JOSEPH T. WEST		18. MOTHER'S NAME (First, Middle, Maiden Surname): CLARA J. ELLIS		
19a. INFORMANT'S NAME (Type/Print): STEWART FUNERAL HOME		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 905 WEST 5 th STREET WAMEGO KANSAS 66547		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WAMEGO CITY CEMETERY		20c. LOCATION — City or Town, State: WAMEGO KANSAS
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Leroy Witzke		22. NAME AND ADDRESS OF FACILITY: LEROY M. & RUSSELL C. WITZKE OF COLUMBIA 5555 TWIN KNOLLS ROAD COLUMBIA MARYLAND 21045		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. stroke	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Respiratory insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary Frank

29c. LICENSE NUMBER: D22567

29d. DATE SIGNED (Month, Day, Year) ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gary Frank 10055 Little Patuxent Col. Md 21044

31. DATE FILED (Month, Day, Year): JAN 3 90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMN-16 Rev 1/89

89 37566

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John E. Wells				2. DATE OF DEATH: Month Nov Day 29 Year 1989	3. TIME OF DEATH: 1:00A M
4. SOCIAL SECURITY NUMBER: 276-03-9165	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): May 18 1913	8. BIRTHPLACE (State or Foreign Country): Ohio
9a. FACILITY NAME (If not institution, give street and number): Potomac Valley Nsg. Center			9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT					
10a. STATE: Virginia	10b. COUNTY: Arlington	10c. CITY, TOWN OR LOCATION: Mclean			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1515 Great Falls Street #332		10f. ZIP CODE: 22101			10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Cauc.
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer		16b. KIND OF BUSINESS/INDUSTRY: State Of Ohio	
17. FATHER'S NAME (First, Middle, Last): Elmer E. Wells				18. MOTHER'S NAME (First, Middle, Maiden Surname): Belle Carpenter	
19a. INFORMANT'S NAME (Type/Print): Thomas B. Wells		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5250 Woodlawn Ave. Chevy Chase, MD 20815			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [X] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Geo. Washington Med. School		20c. LOCATION — City or Town, State: Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard Rendo		22. NAME AND ADDRESS OF FACILITY: Columbia Mortuary Services, Inc. 225 Missouri Ave. NW Washington, D.C. 20011			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Hepatic Failure	1 year
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Hepatic Cirrhosis	10 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Alzheimer's

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [✓] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [✓] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [✓] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [✓] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert C. Macon M.D.
29c. LICENSE NUMBER: D06945
29d. DATE SIGNED (Month, Day, Year): 12/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Robert C. Macon M.D. Rockville, Md 20851

31. DATE FILED (Month, Day, Year): JAN 04 '90
32. REGISTRAR'S SIGNATURE: Lisha Davidson-Randall

ONMN-18 Rev 1/89

89 3756

89 37567

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Susan A Susan J Elizabeth Ward		2. DATE OF DEATH: MONTH 12/30 DAY 89 YEAR 12 30 89	3. TIME OF DEATH: 99:30A M
4. SOCIAL SECURITY NUMBER: 570-24-5053	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-11-08
8. BIRTHPLACE (State or Foreign Country): Frederick co			
8a. FACILITY NAME (If not institution, give street and number): Fred. Health Care Center	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick. md.	9c. COUNTY OF DEATH: Fred.	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Walkersville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9910 Greenbrier Lane		10f. ZIP CODE: 21793	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): nurse	16b. KIND OF BUSINESS/INDUSTRY: health care	
17. FATHER'S NAME (First, Middle, Last): Irving S. Albaugh		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Cramer	
19a. INFORMANT'S NAME (Type/Print): Frederick I. Ward	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 6201 Panama City, FL 32404		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fairmount Cemetery	20c. LOCATION — City or Town, State: Libertytown, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Catharine P. Hartzler	22. NAME AND ADDRESS OF FACILITY: D.D. Hartzler & Sons Libertytown, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. respiratory arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. metastate colon cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D31052	29d. DATE SIGNED (Month, Day, Year): ▶ 1-2-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gino Ashe 10200 Governor Ridge Rd. Woodbine, MD 21797		
31. DATE FILED (Month, Day, Year): JAN 4 '90	32. REGISTRAR SIGNATURE: Julia Davidson-Reynolds	

OHMN-16 Rev 1/89

89 37568

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HOWARD PERSHING WAGNER			2. DATE OF DEATH (Month, Day, Year): Dec. 28, 1989	3. TIME OF DEATH: 8:30 P. M
4. SOCIAL SECURITY NUMBER: 140-03-2133	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 70 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): AUG. 16, 1919	8. BIRTHPLACE (State or Foreign Country): NEW JERSEY
9a. FACILITY NAME (If not institution, give street and number): St. Mary's Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Leonardtown		9c. COUNTY OF DEATH: St. Mary's

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: ST. MARY'S	10c. CITY, TOWN OR LOCATION: LEONARDTOWN	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: CEDAR LANE APTS., #216		10f. ZIP CODE: 20650	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: W.W.II, KOREA, VIETNAM	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CONTROL TOWER OPERATOR	16b. KIND OF BUSINESS/INDUSTRY: CIVIL SERVICE	
17. FATHER'S NAME (First, Middle, Last): WILLIAM WAGNER		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): MRS. ANN R. ESPOSITO		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 WILSTOW RD., BUDD LAKE, NEW JERSEY 07828	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHARLES MEMORIAL GARDENS	20c. LOCATION — City or Town, State: LEONARDTOWN, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward N. Brinsfield		22. NAME AND ADDRESS OF FACILITY: BRINSFIELD FUNERAL HOME P.O. BOX 279, LEONARDTOWN, MD. 20650	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. uremia + congestive heart failure	2wk
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Renal Disease — nephrosclerosis	14 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Generalized arteriosclerosis, severe	74 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

malnutrition
Recent by pass vascular grafts Axillo Femoral

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John F. Fenwick	29c. LICENSE NUMBER: D01380	29d. DATE SIGNED (Month, Day, Year): ▶ 12.29.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John F. Fenwick, M.D. Leonardtown, Md		
31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

89 37569

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. It may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ElTon David Wright
2. DATE OF DEATH: MONTH 11 DAY 29 YEAR 89
3. TIME OF DEATH: 6:30AM M
4. SOCIAL SECURITY NUMBER: 218-96-9849
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS 12 DAYS 29 IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 11-14-25
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): AT HOME
9b. CITY, TOWN OR LOCATION OF DEATH: Chance Md.
9c. COUNTY OF DEATH: Somerset

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY: Somerset
10c. CITY, TOWN OR LOCATION: Chance Md.
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: P.O. Box 105
10f. ZIP CODE: 21816
10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 4-3-44 - 8-25-44
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify: BLACK
14. RACE — American Indian, Black, White, etc. Specify:
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER
16b. KIND OF BUSINESS/INDUSTRY: Domestic
17. FATHER'S NAME (First, Middle, Last): Edgar Wright
18. MOTHER'S NAME (First, Middle, Maiden Surname): TRESSIE GALE
19a. INFORMANT'S NAME (Type/Print): David Wright
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 105 Chance Md. 21816
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. CHARLES Cem.
20c. LOCATION — City or Town, State: Chance Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Anthony E. Ward
22. NAME AND ADDRESS OF FACILITY: 103 Hampden Ave. Princess Anne Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	Minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Heart Disease	Years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ~~Pulmonary Firbosis cause undetermined~~

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Everett Sutter M.D. Everett C Sutter M.D.
29c. LICENSE NUMBER: D10818
29d. DATE SIGNED (Month, Day, Year): 1-2-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P,O.Box 100 Dames Quarter Md 21820
31. DATE FILED (Month, Day, Year): JAN 03 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-18 Rev 1/89

89 37570

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JACK LENOY WHEAT			2. DATE OF DEATH (Month, Day, Year): Dec., 31, 1989	3. TIME OF DEATH: 12:15 P.M. M
4. SOCIAL SECURITY NUMBER: 577-38-9148	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov. 3, 1920	8. BIRTHPLACE (State or Foreign Country): Alabama
9a. FACILITY NAME (If not institution, give street and number): 19809 Westerly Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Poolesville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Poolesville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 19809 Westerly Avenue		10f. ZIP CODE: 20837	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ----------	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Chief Petty Officer	16b. KIND OF BUSINESS/INDUSTRY: United States Navy	
17. FATHER'S NAME (First, Middle, Last): Thomas Allen Wheat		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Beck	
19a. INFORMANT'S NAME (Type/Print): Judith A. Myers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 494, Poolesville, Md. 20837	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lakemont Memorial Gardens	20c. LOCATION — City or Town, State: Davidsonville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave.,Hyattsville, Md. 20781	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Arrest	———
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Non-Small cell Lung Cancer	9 months
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: VA 0101043254	29d. DATE SIGNED (Month, Day, Year): 12/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stephen Hahn, M.D. N.I.H., Bethesda, Maryland

31. DATE FILED (Month, Day, Year): JAN 03 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

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OHMH-16 Rev 1/89

89 37571

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EGBERT WYNTER
2. DATE OF DEATH (Month, Day, Year): 12 30 89
3. TIME OF DEATH: 7:48 PM
4. SOCIAL SECURITY NUMBER: 577-74-9873
5. SEX: 1 [X] M 2 [ ] F
6. AGE (If yrs. last birthday): 53 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)
7. DATE OF BIRTH (Month, Day, Year): 11/16/36
8. BIRTHPLACE (State or Foreign Country): Jamaica
9a. FACILITY NAME (If not institution, give street and number): Leland Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: PRINCE GEORGE
10c. CITY, TOWN OR LOCATION: HYATTSVILLE
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1518 Jefferson Street
10f. ZIP CODE: 20783
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cab Driver
16b. KIND OF BUSINESS/INDUSTRY: Self employed
17. FATHER'S NAME (First, Middle, Last): Vivian Wynter
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bernice Kimm
19a. INFORMANT'S NAME (Type/Print): Blanche Wynter
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1518 Jefferson Street Hyattsville, Md. 20782
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Fort Lincoln Cemetery
20c. LOCATION — City or Town, State: Brentwood, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home, Inc 4217 9th Street, N. W., Washington, D. C. 20011

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Myocardial Infarction	minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Cardiovascular Disease	years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Asthma

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Paul A. DeVore Deputy Medical Examiner
29c. LICENSE NUMBER: D01852
29d. DATE SIGNED (Month, Day, Year) ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Paul A. DeVore, MD 4203 Queensbury Rd Hyattsville MD 20781
31. DATE FILED (Month, Day, Year): JAN 03 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37572

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MOZELLE Gold WARLICK			2. DATE OF DEATH — MONTH DAY YEAR: JANUARY 8, 1989	3. TIME OF DEATH: 12:05 A M
4. SOCIAL SECURITY NUMBER: 213-38-0735	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07-21-06	8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): PHYSICIANS MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: LA PLATA		9c. COUNTY OF DEATH: CHARLES
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Charles	10c. CITY, TOWN OR LOCATION: LaPlata		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt 2 Box 2203		10f. ZIP CODE: 20646		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher		16b. KIND OF BUSINESS/INDUSTRY: Charles County Board of Education
17. FATHER'S NAME (First, Middle, Last): Martin Gold			18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances Blanton	
19a. INFORMANT'S NAME (Type/Print): Evelyn F.W. van der Vate		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10819 Orchard St, Fairfax, VA 22030		
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gardens		20c. LOCATION — City or Town, State: Waldorf, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ J.C. Echols Jr.		22. NAME AND ADDRESS OF FACILITY: Arehart Funeral Home, Inc. LaPlata, Md 20646		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiomyopathy	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertensive Failure Congestive
Rheumatoid Arthritis
Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Henry L Burke MD	D01009	▶ 1-8-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
HENRY L. BURKE, M.D. 115-ALA GRANGE AVEENUE POB 591 LA PLATA MARYLAND 20646

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 10 '90	Julia Davidson-Randall

DNMH-18 Rev 1/89

89 37573

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAVID ROY WOODARD				2. DATE OF DEATH: MONTH 12 DAY 27 YEAR 89	3. TIME OF DEATH: 11:39 P M
4. SOCIAL SECURITY NUMBER: 216-70-9994	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 32 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)		7. DATE OF BIRTH (Month, Day, Year): Oct. 9, 1957	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Calvert Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Prince Frederick		9c. COUNTY OF DEATH: Calvert County	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Calvert	10c. CITY, TOWN OR LOCATION: Chesapeake Beach	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Post Office Box 416		10f. ZIP CODE: 20732	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 1983-1988	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (12) College (1-4 or 5+): None	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): U. S. Military Enlisted	16b. KIND OF BUSINESS/INDUSTRY: U. S. Army	
17. FATHER'S NAME (First, Middle, Last): James Lewis Woodard	18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian -- (Unknown)		
19a. INFORMANT'S NAME (Type/Print): Patricia A. Woodard	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Post Office Box 416, Chesapeake Beach, Md. 20732		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cheltenham Veterans Cemetery	20c. LOCATION — City or Town, State: Cheltenham, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard A. Coleman	22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home Upper Marlboro, Maryland 20772		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Contact gunshot wound to the head	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO — Head only	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-27-89	28b. TIME OF INJURY: 11:39PM	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject shot self
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 260 & Chesapeake Beach Rd., Calvert Co., MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin, M.D., Assistant	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 12-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print): Julia C. Goodin, M.D., Assistant 111 Penn Street, Baltimore, MD 21201		
31. DATE FILED (Month, Day, Year): JAN 09 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37574

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Agnes Wyvill				2. DATE OF DEATH (Month, Day, Year): Dec. 31, 1989	3. TIME OF DEATH: 5:20 p M
4. SOCIAL SECURITY NUMBER: 577-05-0214	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Dec. 10, 1901	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 3705 Donnell Dr., Apt. 302			9b. CITY, TOWN OR LOCATION OF DEATH: Forestville		9c. COUNTY OF DEATH: Prince Geo's
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Forestville			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3705 Donnell Drive		10f. ZIP CODE: 20747		10g. CITIZEN OF WHAT COUNTRY?: U. S. A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): (12); College (1-4 or 5+): None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Credit Manager		16b. KIND OF BUSINESS/INDUSTRY: Public Electric Company	
17. FATHER'S NAME (First, Middle, Last): William H. Wyvill			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa A. Ridgely		
19a. INFORMANT'S NAME (Type/Print): Roland F. Wells		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7319 Marlboro Pike, Forestville, Md. 20747			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Carmel Cemetery		20c. LOCATION — City or Town, State: Upper Marlboro, Md. 20772	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard A. Coleman		22. NAME AND ADDRESS OF FACILITY: Richard A. Coleman Funeral Home Upper Marlboro, Maryland 20772			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio pulmonary Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Hypertensive Artio sclerotic Cardiovascular Disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Linda Whitby Deputy ME	D17162	12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda Whitby, M.D.-------9556 Crain Highway, Route 301, Upper Marlboro, Md. 20772

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 09 '90	Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37575

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TED JOSEPH ZIELINSKI			2. DATE OF DEATH (Month, Day, Year): DEC. 25, 1989	3. TIME OF DEATH: 5:15 PM
4. SOCIAL SECURITY NUMBER: 391-16-0486	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): OCT. 17, 1916	8. BIRTHPLACE (State or Foreign Country): WISCONSIN
9a. FACILITY NAME (If not institution, give street and number): 1003 ARCOLA AVE.		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING		9c. COUNTY OF DEATH: MONTGOMERY
RESIDENCE OF DECEDENT				
10a. STATE: D.C.	10b. COUNTY: NONE	10c. CITY, TOWN OR LOCATION: WASHINGTON		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6817 GEORGIA AVE., N.W.		10f. ZIP CODE: 20012		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12):	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): COURT REPORTER		16b. KIND OF BUSINESS/INDUSTRY: ARMED SERVICES
17. FATHER'S NAME (First, Middle, Last): CHARLES ZIELINSKI		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY IWASKO		
19a. INFORMANT'S NAME (Type/Print): GLORIA NORRIS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5535 COLUMBIA PIKE #206, ARLINGTON, VA. 22204		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CHAMBERS CREMATORY		20c. LOCATION — City or Town, State: RIVERDALE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W.W. Chambers MOOO91		22. NAME AND ADDRESS OF FACILITY: W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC SMALL CELL LUNG CANCER	11 MOS.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC SMALL CELL LUNG CANCER	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James S. Perry MD	26539 (COLORADO)	▶ 26 DEC 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES S. PERRY MD , 6825 16th ST. N.W., WASH. D.C.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 89	Jutta Davidson-Randall

1+1

DHMH-18 Rev 1/89

89 37576

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Naomi Christine Walker		2. DATE OF DEATH (Month, Day, Year): Dec. 24, 1989	3. TIME OF DEATH: 9:15 a.m. M
4. SOCIAL SECURITY NUMBER: 214-36-2574	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 82 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 24, 1989
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Wilson Health Care Center	9b. CITY, TOWN OR LOCATION OF DEATH: Gaithersburg	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Mitchellville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 13907 Woodmore Road	10f. ZIP CODE: 20716	10g. CITIZEN OF WHAT COUNTRY? United States of Amer.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Edward S. Walker	18. MOTHER'S NAME (First, Middle, Maiden Surname): Anne Harman		
19a. INFORMANT'S NAME (Type/Print): John W. Mitchell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box, 279, Upper Marlboro, Md. 20772		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Oak Cemetery	20c. LOCATION — City or Town, State: Mitchellville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave, Hyattsville, Md. 20781		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac arrest	3 min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Parkinsonism	2 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: 07231	29d. DATE SIGNED (Month, Day, Year): ▶ 12-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James R. Moore Jr. 207 Brookes Ave Gaithersburg Md.		
31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

(4)

89 37577

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) 2 Clara Wilkins		2. DATE OF DEATH (Month, Day, Year) December 16, 1989	3. TIME OF DEATH 6:15 P.M.
4. SOCIAL SECURITY NUMBER 220-05-1977	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year) 7/17/94	8. BIRTHPLACE (State or Foreign Country) md		
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH Easton	9c. COUNTY OF DEATH Talbot	

RESIDENCE OF DECEDENT

10a. STATE Md	10b. COUNTY Talbot	10c. CITY, TOWN OR LOCATION Wye mills	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER R F D	10f. ZIP CODE 21679	10g. CITIZEN OF WHAT COUNTRY? U S A	
11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 3rd; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) William Pauls	18. MOTHER'S NAME (First, Middle, Maiden Surname) ?		
19a. INFORMANT'S NAME (Type/Print) Catherine Lee	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wye mills P.O. 21679		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Sandtown	20c. LOCATION — City or Town, State Hillsboro Cav. md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Leage H Caswell	22. NAME AND ADDRESS OF FACILITY 319 Dover st. Easton md		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	
	DUE TO (OR AS A CONSEQUENCE OF): b. Brainstem lower lobe bronchopneumonia	1 week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): c. (2) hemiplegia ((13) MCA thrombosis)	1 week
	DUE TO (OR AS A CONSEQUENCE OF): d. ASCVD. & complete heart block	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Albert Dawkins M.D.	MD-D7872	▶ 12 18 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
ALBERT T. DAWKINS JR. M.D. 508 IDLE WILD AVE EASTON, MARYLAND 21601

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 '89	Julia Leighton Rhodes

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

2

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89 37578

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sherry Lynn Bradley			2. DATE OF DEATH (Month, Day, Year): 12-23-89	3. TIME OF DEATH: 3:25 AM M
4. SOCIAL SECURITY NUMBER: 216-70-0966	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 31 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10- 22- 1958	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Rt. 349/E. of Rt. 50		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico County

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 216 PEMBERTON DRIVE		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 YEARS; College (1-4 or 5+): ----	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INSTRUCTOR	16b. KIND OF BUSINESS/INDUSTRY: CATALOGE SHOW ROOM	
17. FATHER'S NAME (First, Middle, Last): CLINCLE LANICE BULLIS, SR		18. MOTHER'S NAME (First, Middle, Maiden Surname): JUANITA --- BEAUCHAMP	
19a. INFORMANT'S NAME (Type/Print): MARY ELLEN HILL		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX 99 , HOBBS RD, RT 3, SALISBURY , MD 21801	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/27/89	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SPRINGHILL MEMORY GARDENS	20c. LOCATION — City or Town, State: HEBRON, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John M. Holloway		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	XXX 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 ☐ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) xx Scene			
27. MANNER OF DEATH: 1 ☐ Natural 2 XX Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-23-89	28b. TIME OF INJURY: 2:00 AM	28c. INJURY AT WORK? 1 ☐ YES 2 XX NO	28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/fixed object
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Impact Rt. 349/E. of Rt. 50, Salisbury Wicomico County, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and dua to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 12-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 PENN STREET, BALTIMORE, MD 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37579

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EUGENE ROSCOE Bailey			2. DATE OF DEATH: MONTH 12 DAY 22 YEAR 89	3. TIME OF DEATH: 904 A M
4. SOCIAL SECURITY NUMBER: 220-32-0320	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3- 30- 1908	8. BIRTHPLACE (State or Foreign Country): TEXAS
9a. FACILITY NAME (If not institution, give street and number): Peninsula General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: PARKWOOD II, APT. 204, BEAGLIN DR		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: NAVY WWII	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGHSCHOOL; College (1-4 or 5+): ---	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BROKER	16b. KIND OF BUSINESS/INDUSTRY: REAL ESTATE	
17. FATHER'S NAME (First, Middle, Last): LAYMAN WILBER BAILEY		18. MOTHER'S NAME (First, Middle, Maiden Surname): BEATRICE ---- LUSK	
19a. INFORMANT'S NAME (Type/Print): AMANDA LOUISE TWIGG BAILEY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PARKWOOD II, APT. 204, BEAGLIN DR, SALISBURY, MD 21801	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) 12/24/89	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WICOMICO MEMORIAL PARK	20c. LOCATION — City or Town, State: SALISBURY, MD 21801	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. myocardial infarction	30 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypercalcemia
dementia

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D 30853	29d. DATE SIGNED (Month, Day, Year): 12/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles B. Silvia Jr MD PGHMC		
31. DATE FILED (Month, Day, Year): DEC 26 '89	32. REGISTRAR'S SIGNATURE: [signature]	

IVA 5

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37580

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEAMON JOHN BETTS			2. DATE OF DEATH (Month, Day, Year): December 23, 1989	3. TIME OF DEATH: 8:35 pM
4. SOCIAL SECURITY NUMBER: 143-01-2353	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 10, 1899	8. BIRTHPLACE (State or Foreign Country): Corning, N.Y.
9a. FACILITY NAME (If not institution, give street and number): Frederick Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick,

RESIDENCE OF DECEDENT

10a. STATE: New JERSEY	10b. COUNTY: UNION	10c. CITY, TOWN OR LOCATION: WESTFIELD	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 816 Fairacres Ave.	10f. ZIP CODE: 07090	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW I	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 + & Business School; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Building Contractor	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Tracy G. Betts		18. MOTHER'S NAME (First, Middle, Maiden Surname): Estella L. Robbins	
19a. INFORMANT'S NAME (Type/Print): Dr. Lee J. Betts	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8014 Clearfield Road Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory	20c. LOCATION — City or Town, State: Smithsburg, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr.	22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 North Market St. Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CEREBRO-VASCULAR DISEASE

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Geo. I. Smith M.D.	29c. LICENSE NUMBER: D10587	29d. DATE SIGNED (Month, Day, Year): December 24, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): G.I. Smith, Jr. M.D. 300 West 9th Street Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): DEC 26 1989	32. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37581

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Melvin Brown / Melvin Mathias BROWN			2. DATE OF DEATH (Month, Day, Year) Dec 7 89		3. TIME OF DEATH 5A M
4. SOCIAL SECURITY NUMBER 217-01-5896	5. SEX 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 5-4-1908	8. BIRTHPLACE (State or Foreign Country) Frederick
9a. FACILITY NAME (If not institution, give street and number) 9017 Baltimore National Pike			9b. CITY, TOWN OR LOCATION OF DEATH Bartonville		9c. COUNTY OF DEATH Frederick

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 9017 Baltimore National Pike		10f. ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 7 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Melvin Brown		18. MOTHER'S NAME (First, Middle, Maiden Surname) Maggie Proctor Carroll	
19a. INFORMANT'S NAME (Type/Print) Mrs. Carrie Brown		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9017 Baltimore National Pike, Frederick, MD 21701	
20a. METHOD OF DISPOSITION ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Hopehill Cemetery	20c. LOCATION — City or Town, State Hopeland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles E Hicks III M00290	22. NAME AND ADDRESS OF FACILITY C.E. Hicks, III 1922 Forest Dr., Annapolis, Md 21401		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pulmonary failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Metastatic Carcinoma of Prostate	2 yrs
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Cancer of Prostate	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Morris A Wilkinson MD	D-20279	▶ 7 Dec 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Morris A Wilkinson MD 700 N. Market St Frederick, Md

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 11 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

Item7 1-11-90 FilmG659 W.H. Per F/H

89 37582

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sally Searing Burns			2. DATE OF DEATH (Month, Day, Year): 12 24 89	3. TIME OF DEATH: 7:43 PM
4. SOCIAL SECURITY NUMBER: 219-44-8714	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 45 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-26-~~89~~ 44	8. BIRTHPLACE (State or Foreign Country): NY
9a. FACILITY NAME (If not institution, give street and number): Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Westminster		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 829 Gist Road		10f. ZIP CODE: 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk		16b. KIND OF BUSINESS/INDUSTRY: Local Government
17. FATHER'S NAME (First, Middle, Last): Joseph P. Searing		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ruth A. Michel		
19a. INFORMANT'S NAME (Type/Print): Luke K. Burns, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 829 Gist Road, Westminster, MD 21157		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westminster Cemetery		20c. LOCATION — City or Town, State: Westminster, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert K. Pritts, Sr.		22. NAME AND ADDRESS OF FACILITY: Pritts Funeral Home & Chapel 412 Washington Rd. Westminster, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Breast Cancer	22 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Renal Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John Earl Stokes III MD	D33330	▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Earl Stokes III MD Union Memorial Hospital

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	Julia Davidson-Randall

OHMN-18 Rev 1/89

89 37583

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph Carl Burner			2. DATE OF DEATH (Month, Day, Year): november 29 1989	3. TIME OF DEATH: 1547 p M
4. SOCIAL SECURITY NUMBER: 220-26-2631	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 29, 1925	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5870 Rosebay Court		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter	16b. KIND OF BUSINESS/INDUSTRY: Self-Employed	
17. FATHER'S NAME (First, Middle, Last): John Carl Burner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Elizabeth Butler	
19a. INFORMANT'S NAME (Type/Print): Mr. John J. Burner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 123 East Fourth Street, Frederick, Md. 21701	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frederick Memorial Park	20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allan H Ruby 00703		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Md.21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hemorrhagic Shock	
DUE TO (OR AS A CONSEQUENCE OF):	b. UPPER G.I. Bleeding	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. Peptic Ulcer Disease	
DUE TO (OR AS A CONSEQUENCE OF):	d. Severe End-stage COPD	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James S. Grissom MD	D 21944	▶ 12/1/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. James S. Grissom, MD, 1475 Taney Avenue, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 01 1989	Julia Davidson-Randall

OHMH-18 Rev 1/89

89 37584

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ronald G. Buckley		2. DATE OF DEATH (Month, Day, Year): December 13, 1989	3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 205-42-8720	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 36 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 13, 1953
8. BIRTHPLACE (State or Foreign Country): PA.			
9a. FACILITY NAME (If not institution, give street and number): 7806 Grand View Place	9b. CITY, TOWN OR LOCATION OF DEATH: Middletown	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT			
10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Middletown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 7806 Grand View Place	10f. ZIP CODE: 21769	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesperson/minister	16b. KIND OF BUSINESS/INDUSTRY: Retail sales	
17. FATHER'S NAME (First, Middle, Last): Thomas H. Buckley	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sara Meta Saque		
19a. INFORMANT'S NAME (Type/Print): Pamela Bedell Buckley	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7806 Grand View Place, Middletown, Md. 21769		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillside Cemetery	20c. LOCATION — City or Town, State: Roslyn, Pennsylvania	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sandra L. Lemmer	22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary Arrest	1 minute
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Central Nervous System Toxoplasmosis	3 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Acquired Immune Deficiency Syndrome	1 year
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Pamela Jo Harris MD	10742	▶ December 14,1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Pamela Jo Harris, M.D., 3801 Connecticut Ave., N.W., Washington, D.C. 20008

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 15 1989	Julia Davidson-Pinkett

DHMH-18 Rev 1/89

89 37585

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frieda Augusta Bowles — Frieda A. Bowles
2. DATE OF DEATH: MONTH 10 DAY 24 YEAR 89
3. TIME OF DEATH: 12:20 a.m.
4. SOCIAL SECURITY NUMBER: 577-84-2254
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 4/13/98
8. BIRTHPLACE (State or Foreign Country): Pa.
9a. FACILITY NAME (If not institution, give street and number): Reeders Mem. Home
9b. CITY, TOWN OR LOCATION OF DEATH: Boonsboro
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Jefferson
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1210 Arnoldstown Rd.
10f. ZIP CODE: 21755
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker
16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): William Eberlein
18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown
19a. INFORMANT'S NAME (Type/Print): Richard E. Bowles
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1210 Arnoldstown Rd., Jefferson, Md. 21755
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Parklawn Cemetery
20c. LOCATION — City or Town, State: Rockville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B Thompson
22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. probable myocardial infarction
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D32518
29d. DATE SIGNED (Month, Day, Year): 12/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): DEC 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank Donaldson BOYER,SR.				2. DATE OF DEATH (Month, Day, Year): November 11, 1989	3. TIME OF DEATH: 2:55 P.M
4. SOCIAL SECURITY NUMBER: 218-30-9995	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)		7. DATE OF BIRTH (Month, Day, Year): Aug. 8, 1915	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 8707-A Liberty Road		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer		16b. KIND OF BUSINESS/INDUSTRY: Farming	
17. FATHER'S NAME (First, Middle, Last): Emmert J. Boyer		18. MOTHER'S NAME (First, Middle, Maiden Surname): Edith M. Winks			
19a. INFORMANT'S NAME (Type/Print): Mrs. Catherine M. Boyer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8707-A Liberty Road, Frederick, Md. 21701			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens		20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Allan H Ruby M00703		22. NAME AND ADDRESS OF FACILITY: Keeney and Basford P.A. Funeral Home 106 East Church Street, Frederick, Md.21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BRAIN TUMOR

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

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24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD

29c. LICENSE NUMBER: D32171

29d. DATE SIGNED (Month, Day, Year): 11/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Richard L. Gough, MD. 19 Frederick Street, Walkersville, Md. 21793

31. DATE FILED (Month, Day, Year): NOV 13 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37587

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Cleared by Dr. Rogers

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jesse Baker		2. DATE OF DEATH (Month, Day, Year): November 27, 1989	3. TIME OF DEATH: 4:15 P M
4. SOCIAL SECURITY NUMBER: 577-05-4681	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 15, 1907
8. BIRTHPLACE (State or Foreign Country): Henrico, N.C.			
8a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 8830 Piney Branch Road, #502	10f. ZIP CODE: 20903	10g. CITIZEN OF WHAT COUNTRY?: United States	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operating Engineer	16b. KIND OF BUSINESS/INDUSTRY: Federal Government	
17. FATHER'S NAME (First, Middle, Last): Henry Baker	18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Bell Mason		
19a. INFORMANT'S NAME (Type/Print): Elizabeth Baker	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): B830 Piney Branch Rd., #502, Silver Spring, Md. 20903		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Natl. Mem. Park	20c. LOCATION — City or Town, State: Laurel, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Harvin E. Hartt	22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service, Inc 7400 Georgia Ave.N.W., Washington, D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Septic Shock	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 08544	29d. DATE SIGNED (Month, Day, Year): 01/16/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John Meremdino, M.D., 4701 Randolph Road, Rockville, Maryland		
31. DATE FILED (Month, Day, Year): JAN 18 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Fonseca	

DHMH-15 Rev 1/89

89 37588

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the [illegible]. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MAY BEULAH BLICKENSTAFF			2. DATE OF DEATH (Month, Day, Year): 12 27 89	3. TIME OF DEATH: 9 36 PM M
4. SOCIAL SECURITY NUMBER: 220-52-1663	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 22, 1898	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Myersville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 12427 Stottlemyer Road		10f. ZIP CODE: 21773	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Home

17. FATHER'S NAME (First, Middle, Last): Daniel Smith	18. MOTHER'S NAME (First, Middle, Maiden Surname): Maggie Myers

19a. INFORMANT'S NAME (Type/Print): Herman Blickenstaff	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4647 Foxville Road, Sabillasville, Maryland 21780

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salem United Methodist Cemetery	20c. LOCATION — City or Town, State: Wolfsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis L Davis	22. NAME AND ADDRESS OF FACILITY: Ricketts Funeral Home 504 Main Street, Myersville, Maryland 21773	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Probable myocardial infarction	minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. diverticulitis	36 hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. pneumonia	36 hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Extensive diverticulosis
Inflammatory bowel disease

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINDS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and dus to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Sara Hultsch-Smith M.D.	29c. LICENSE NUMBER: 36701	29d. DATE SIGNED (Month, Day, Year): 12-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sara Hultsch-Smith M.D. 915 Tollhouse Rd. Suite Frederick Md.

31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-18 Rev 1/89

89 37589

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BOBBI J. Bobbi Jo BURKER BURKER		2. DATE OF DEATH (Month, Day, Year): 12 28 89	3. TIME OF DEATH: 8:39 P M
4. SOCIAL SECURITY NUMBER: 212-92-8543	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 15 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 5, 1974 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cumberland	9c. COUNTY OF DEATH: Allegany County	

RESIDENCE OF DECEDENT

10a. STATE: West Va.	10b. COUNTY: Mineral	10c. CITY, TOWN OR LOCATION: Ridgely	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 3, Box 394	10f. ZIP CODE: 26753	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): student	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Robert Elwood Burker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan Ann Monninger	
19a. INFORMANT'S NAME (Type/Print): Robert Burker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 3, Box 394, Ridgely, W. Va. 26753	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park	20c. LOCATION — City or Town, State: Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich		22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Head Injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 XX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 XX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural XX ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-28-89	28b. TIME OF INJURY: 7:45P M	28c. INJURY AT WORK? 1 ☐ YES 2 XX NO
	28d. DESCRIBE HOW INJURY OCCURED: Passenger in auto/ fixed object impact		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): highway	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 48 W. near Seton Dr. exit, Allegany Co., MD	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin, M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D., Assistant 111 Penn Street, Baltimore, MD 21201 v1		
31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37590

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Anthony Bortolas				2. DATE OF DEATH (Month, Day, Year): December 28, 1989	3. TIME OF DEATH: 1:30 a.m.
4. SOCIAL SECURITY NUMBER: 189-24-6028	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 56 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)		7. DATE OF BIRTH (Month, Day, Year): August 2, 1933	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Greater Laurel Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Laurel		9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Laurel		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 8808 Hunting Lane, #101		10f. ZIP CODE: 20708		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th Grade; College (1-4 or 5+): ----------		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Salesman		16b. KIND OF BUSINESS/INDUSTRY: Various Stores	
17. FATHER'S NAME (First, Middle, Last): Antonio Bortolas		18. MOTHER'S NAME (First, Middle, Maiden Surname): Gelinda Marcolina			
19a. INFORMANT'S NAME (Type/Print): Rosanne McHugh (Daughter)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3 Wooded Lane, Media, Pennsylvania 19063			
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Metropolitan Crematory		20c. LOCATION — City or Town, State: Alexandria, Virginia	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Christina L. Kopasz		22. NAME AND ADDRESS OF FACILITY: Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave. Hyattsville, Md. 20781			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer of Left Lung with Metastasis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mizar H.A. Baig, M.D.	29c. LICENSE NUMBER: D12089	29d. DATE SIGNED (Month, Day, Year): ▶ December 29, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mizar H.A. Baig, M.D. Greater Laurel Beltsville Hospital, Laurel, Md. 20707		
31. DATE FILED (Month, Day, Year): JAN 31 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37591

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 - 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last): Sarah Virginia C. Bowdle		2. DATE OF OEATH (Month, Day, Year): Dec. 27, 1989	3. TIME OF DEATH: 11:45 AM
4. SOCIAL SECURITY NUMBER: 165-12-5835	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 9, 1911 — 8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 6672 Palmer Mill Road		9b. CITY, TOWN OR LOCATION OF OEATH: Hurlock, Md. 21643	9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Hurlock, Maryland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 6672 Palmer Mill Road		10f. ZIP COOE: 21643	10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS OECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondery (0-12): N/A — College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Food Manager	16b. KIND OF BUSINESS/INDUSTRY: School	
17. FATHER'S NAME (First, Middle, Last): Lee Corkran		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Stevens	
19a. INFORMANT'S NAME (Type/Print): Shirley B. Truitt		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Whaleysville, Maryland 21872	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, cremetory or other place): Maryland Veterans Cem. Beulah, Md.	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Hoblett		22. NAME AND ADDRESS OF FACILITY: Williamson Funeral Home 311 S. Main St., Fed., Md. 21632	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter tha mode of dying, such as cerdiac or respiratory arreat, ahock, or heart failure. Llat only one cause on each lina.

		Approximata Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in daath) →	a. Carcinoma of the colon	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially liat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Congestive heart failure

24a. WAS AN AUTOPSY PERFORMEO? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY — M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCUREO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jack C. Lewis MD	29c. LICENSE NUMBER: MD L-7064	29d. DATE SIGNEO (Month, Day, Year): ▶ 4/Jan/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JACK C. LEWIS. MD PO Box 329 Selbyville, DE 19975		
31. DATE FILED (Month, Day, Year): JAN 9 '90	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall	

OHMH-16 Rev 1/89

89 37592

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDWARD VAC HEL BECK				2. DATE OF DEATH (Month, Day, Year): December 25, 1989	3. TIME OF DEATH: x 5 A M
4. SOCIAL SECURITY NUMBER: 219 07 6782	5. SEX: Male (1 ☐ M 2 ☐ F) xx	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): APR. 13, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): At Home Hawthore Ave. (# 23)			9b. CITY, TOWN OR LOCATION OF DEATH: Rock Hall		9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Rock Hall	10d. INSIDE CITY LIMITS? (1 ☒ YES 2 ☐ NO) xx
10e. STREET AND NUMBER: # 23 Hawthorne Ave		10f. ZIP CODE: 21661	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: Married (1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? (1 ☒ YES 2 ☐ NO) IF YES, GIVE WAR OR DATES: Yes WW 2	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) (1 ☐ YES 2 ☒ NO) Specify: NO	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 4+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Waterman	16b. KIND OF BUSINESS/INDUSTRY: River and Bay	
17. FATHER'S NAME (First, Middle, Last): Charles Wesley Beck		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen B. Burgess	
19a. INFORMANT'S NAME (Type/Print): Rose Buckley Beck		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): # 23 Hawthorne Ave. Rock Hall, Md. 21661	
20a. METHOD OF DISPOSITION (1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)): Burial	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Chapel Cem. (12/28/89)	20c. LOCATION — City or Town, State: Rock Hall, Md. 21661	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells		22. NAME AND ADDRESS OF FACILITY: J. Willis Wells P.O. Box # 264 Chestertown, Md. 21620	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory arrest	
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. arteriosclerotic heart disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? (1 ☐ YES 2 ☒ NO)	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? (1 ☐ YES 2 ☐ NO)

25. WAS CASE REFERRED TO MEDICAL EXAMINER? (1 ☐ YES 2 ☒ NO)	26. PLACE OF DEATH (Check only one) HOSPITAL: (1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA) OTHER: (4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify))			
27. MANNER OF DEATH (1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined)	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? (1 ☐ YES 2 ☐ NO)	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Bienenfeld	29c. LICENSE NUMBER: D33514	29d. DATE SIGNED (Month, Day, Year): ▶ 12-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 23) (Type, Print): M. Bienenfeld, M.D. Kent & Q. Anne Hosp. Chestertown, Md. 21620		
31. DATE FILED (Month, Day, Year): DEC 26 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

13

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn C. Browne			2. DATE OF DEATH (Month, Day, Year): 12 27 89	3. TIME OF DEATH: 0400 M
4. SOCIAL SECURITY NUMBER: 060-14-1853	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 03-19-04	8. BIRTHPLACE (State or Foreign Country): SALISBURY, MD.
9a. FACILITY NAME (If not institution, give street and number): 121 Flamingo Road		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO: X
10e. STREET AND NUMBER: 121 FLAMINGO ROAD		10f. ZIP CODE: 21801		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO: X. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO: X. Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th. College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): BUYER		16b. KIND OF BUSINESS/INDUSTRY: SUPERVISOR- GIMBELS
17. FATHER'S NAME (First, Middle, Last): GEORGE DESHIELDS			18. MOTHER'S NAME (First, Middle, Maiden Surname): SARAH CONWAY	
19a. INFORMANT'S NAME (Type/Print): JAMES BROWNE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SPRINGHILL MEMORY GARDEN		20c. LOCATION — City or Town, State: HEBRON, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Loretta B. Jolley		22. NAME AND ADDRESS OF FACILITY: JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920 SALISBURY, MD. 21801		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO: X

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO: X

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify): X

27. MANNER OF DEATH: 1 ☒ Natural: X 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.: X

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John T. Bulkeley Deputy M.E.	D03599	▶ 12-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John T. Bulkeley, M.D. - Salisbury, Maryland

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 3 '90	Julie Davidson Parker

5

DHMH-18 Rev 1/89

89 37594

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LOUIS STANFORD Beckett
2. DATE OF DEATH (Month, Day, Year): 12-28-89
3. TIME OF DEATH: 1730 M
4. SOCIAL SECURITY NUMBER: 218-24-3952
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 62 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-1-27
8. BIRTHPLACE (State or Foreign Country): SNOWHILL, MD.
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND
9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: DELAWARE
10b. COUNTY: SUSSEX
10c. CITY, TOWN OR LOCATION: DELMAR
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: RTE. 2, BOX 199A
10f. ZIP CODE: 19940
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: AFRO-AMERICAN
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th. | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER
16b. KIND OF BUSINESS/INDUSTRY: FARM- FACTORY
17. FATHER'S NAME (First, Middle, Last): OTIS BECKETT
18. MOTHER'S NAME (First, Middle, Maiden Surname): WILSIE WARD
19a. INFORMANT'S NAME (Type/Print): ALMETA TIMMONS BECKETT
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS ABOVE
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. JOHN-TAYLORS-GATE
20c. LOCATION — City or Town, State: SNOWHILL, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Loretta B. Jolley
22. NAME AND ADDRESS OF FACILITY: JOLLEY MEMORIAL CHAPEL RTE. 2, BOX 920, SALISBURY, MD. 21801

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. metastatic lung Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: JG Grasso MD
29c. LICENSE NUMBER: D 20507
29d. DATE SIGNED (Month, Day, Year): 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph A. Grasso 145 E. Carroll St. Salisbury MD
31. DATE FILED (Month, Day, Year): JAN 3 '90
32. REGISTRAR'S SIGNATURE

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DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be obtained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37595

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 1314(, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): PRESTON G. CARPENTER				2. DATE OF DEATH (Month, Day, Year): Dec. 31, 1989	3. TIME OF DEATH: 11:10 PM
4. SOCIAL SECURITY NUMBER: 219-03-1893	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3/04/11	8. BIRTHPLACE (State or Foreign Country): W Virginia
9a. FACILITY NAME (If not institution, give street and number): MERIDIAN NURSING CENTER			9b. CITY, TOWN OR LOCATION OF DEATH: LAPLATA		9c. COUNTY OF DEATH: CHARLES

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CHARLES	10c. CITY, TOWN OR LOCATION: WALDORF	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 2000 Amberleaf PL T-4		10f. ZIP CODE: 20601	10g. CITIZEN OF WHAT COUNTRY?: U.S

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Conductor	16b. KIND OF BUSINESS/INDUSTRY: Railroad	
17. FATHER'S NAME (First, Middle, Last): Charles B. Carpenter		18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie unobtainable	
19a. INFORMANT'S NAME (Type/Print): Mrs. Sponcello R. Carpenter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2000 Amber leaf Pl. T4 Waldorf, MD. 20602	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Trinity Memorial Gargens	20c. LOCATION — City or Town, State: Waldorf, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dana A Melbach		22. NAME AND ADDRESS OF FACILITY: Robert E. Wilhelm, Inc. 4308 Suitland, Rd. Suitland, MD. 20746	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
c. Diabetes
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D22574	29d. DATE SIGNED (Month, Day, Year): ▶ 1/1/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JAN 10 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 37596

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE CARTNER, Jr.			2. DATE OF DEATH (Month / Day / Year): 12 / 30 / 89	3. TIME OF DEATH: 9:45 a. M
4. SOCIAL SECURITY NUMBER: 578-34-8288	5. SEX: XX 1 M 2 F	6. AGE (In yrs. last birthday): 59 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 6/11/30	8. BIRTHPLACE (State or Foreign Country): Wash., D.C.
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL CENTER CLINTON, MD.		9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH: PRINCE GEORGE'S	
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Clinton	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 XX NO	
10a. STREET AND NUMBER: 6705 Crafton Lane		10f. ZIP CODE: 20735	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Automoblie Salesman	16b. KIND OF BUSINESS/INDUSTRY: Jim Tolson Motors	
17. FATHER'S NAME (First, Middle, Last): George S. Cartner, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Denslow		
19a. INFORMANT'S NAME (Type/Print): Betty R. Cartner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Same as 10a-10f.		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 XX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory	20c. LOCATION — City or Town, State: Clinton, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mat D. DeSales		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Maryland 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest — 2 hrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acid Overload

DUE TO (OR AS A CONSEQUENCE OF):

c. Portal Vein Obstruction

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: RENAL FAILURE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Levine D	29c. LICENSE NUMBER: D24945	29d. DATE SIGNED (Month, Day, Year): ▶ December 30, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 7801 Old Branch Ave # 400 Clinton, MD 20735		
31. DATE FILED (Month, Day, Year): JAN 10 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37597

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Naomi S. Cooper			2. DATE OF DEATH (Month, Day, Year): Dec. 29 89	3. TIME OF DEATH: 3:34 PM
4. SOCIAL SECURITY NUMBER: 062-20-4486	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 9, 1925	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hosp		9b. CITY, TOWN OR LOCATION OF DEATH: Sil. Spg.		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 931-2 Rosemary Hills Drive		10f. ZIP CODE: 20910		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personnel Management Specialist		16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): Theophilus A. Cooper			18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Howard	
19a. INFORMANT'S NAME (Type/Print): Ruth Beese		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 133 E. 46th Street Brooklyn, New York 11203		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): J. William Lee's Sons		20c. LOCATION — City or Town, State: Washington, D.C.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Marvin E. Hatch		22. NAME AND ADDRESS OF FACILITY: McGuire Funeral Service 7400 Georgia Avenue N.W. Washington, D.C.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial D.S. DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D09975

29d. DATE SIGNED (Month, Day, Year): Dec 29 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type or Print)

31. DATE FILED (Month, Day, Year): JAN 9 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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ITEM: 7 per FH G-659
1-29-90 cm

89 37598

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RICHARD ~~RICHARD~~ M. CLENDENIN			2. DATE OF DEATH Month: December Day: 5 Year: 1989	3. TIME OF DEATH: 0730 AM
4. SOCIAL SECURITY NUMBER: 557-09-6625	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (If under 1 year: Months / Days / Hours / Min.)	7. DATE OF BIRTH: 10-18-05 ~~10/10/05~~	8. BIRTHPLACE (State or Foreign Country): California
9a. FACILITY NAME (If not institution, give street and number): Homewood Retirement Center		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1614 Rock Creek Drive		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII, Korea 1934-1963	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Military		16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): William Joseph Humphreys Clendenin		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elsie Madeline Rose Flynn		
19a. INFORMANT'S NAME (Type/Print): Mrs. Nedda Louise Clendenin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1614 Rock Creek Drive Frederick, MD 21701		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington National Cemetery		20c. LOCATION — City or Town, State: Arlington, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr.		22. NAME AND ADDRESS OF FACILITY: Robert E. Dailey & Son Funeral Homes PA 1201 N. Market St. Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ~~A Resp~~ CARCINOMA of the Lung	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA. OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
George I. Smith, Jr. M.D.	D10587	▶ 12/5/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George I. Smith, Jr. MD 300 West 9th St. Frederick, MD 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 07 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37599

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAZEL DERR CORKRAN (CORKRAN)			2. DATE OF DEATH (Month, Day, Year): 12 31 89		3. TIME OF DEATH: 0045 M
4. SOCIAL SECURITY NUMBER: 218-20-7864	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): APRIL 23, 1915	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: DORCHESTER	10c. CITY, TOWN OR LOCATION: HURLOCK	10d. INSIDE CITY LIMITS? XX 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 506 ACADEMY STREET		10f. ZIP CODE: 21643	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 X Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LIBRARIAN	16b. KIND OF BUSINESS/INDUSTRY: COUNTY LIBRARY
17. FATHER'S NAME (First, Middle, Last): BRADY M. DERR		18. MOTHER'S NAME (First, Middle, Maiden Surname): JENNIE FRANTZ	
19a. INFORMANT'S NAME (Type/Print): MICHAEL D. CORKRAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P. O. BOX A, HURLOCK, MD 21643	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): EAST NEW MARKET CEMETERY	20c. LOCATION — City or Town, State: EAST NEW MARKET, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Leonard M. Zeller		22. NAME AND ADDRESS OF FACILITY: ZELLER FUNERAL HOME EAST NEW MARKET, MD 21631	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. respiratory failure	4 months
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. chronic obstructive lung disease and pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: status post colon resection and abdominal wall resection for colon carcinoma

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: William J Nagel MD	29c. LICENSE NUMBER: D22460	29d. DATE SIGNED (Month, Day, Year): ▶ 12-31-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WILLIAM J NAGEL, MD PGHMC Salisbury, Md 21801		
31. DATE FILED (Month, Day, Year): JAN 17 '90	32. REGISTRAR'S SIGNATURE: Tina Davidson-Randell	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

89 37600

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Patricia Eileen CRAWFORD — PATRICIA EILEEN CRAWFORD
2. DATE OF DEATH (Month, Day, Year): Dec. 20, 1989
3. TIME OF DEATH: 8 P M
4. SOCIAL SECURITY NUMBER: 212-50-9144
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 41 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12 19 48
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Middletown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7097 Shale Court
10f. ZIP CODE: 21769
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales representative
16b. KIND OF BUSINESS/INDUSTRY: Retail sales - Department Store
17. FATHER'S NAME (First, Middle, Last): Raymond Chester Warren
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Smith
19a. INFORMANT'S NAME (Type/Print): James Crawford
19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7097 Shale Court, Middletown, Md. 21769
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens
20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C. C. Basford M00021
22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home, 106 East Church St., Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	SUDDEN CARDIAC DEATH	3 DAYS
DUE TO (OR AS A CONSEQUENCE OF): b.	ACUTE ANTERIOR MI	3 DAYS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
HYPOXIC ENCEPHALOPATHY
ARDS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ ND
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ ND
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: S Kahan MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 12-21-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 4 W 7th ST FREDERICK MD S. KAHAN MD
31. DATE FILED (Month, Day, Year): DEC 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37601

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ida Mae CROUSE
2. DATE OF DEATH: Month: December Day: 21 Year: 89
3. TIME OF DEATH: 430 P M
4. SOCIAL SECURITY NUMBER: 213-74-8891
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 91 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Mar 2, 1898
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Northampton Manor Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 110 South Jefferson Street
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): George W. Cramer
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Elizabeth Zimmerman
19a. INFORMANT'S NAME (Type/Print): Mrs. Kathryn C. Staley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8224 Yellow Springs Road, Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery
20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C. C. Basford M00021
22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home, 106 East Church St., Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure	years
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Casper C. Cline, Jr. M.D.
29c. LICENSE NUMBER: D16428
29d. DATE SIGNED (Month, Day, Year): ▶ 12/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Casper E. Cline, III, M.D., 300 West Ninth St., Frederick, Md. 21701
31. DATE FILED (Month, Day, Year): DEC 22 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37602

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) NORMAN ANDREW CRONE / NORMAN ANDREW CRONE.			2. DATE OF DEATH MONTH DAY YEAR: Dec. 24, 1989	3. TIME OF DEATH: 12:15 PM
4. SOCIAL SECURITY NUMBER: 577-26-7453	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 67 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 06/09/22	8. BIRTHPLACE (State or Foreign Country): Kentucky
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Walkersville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 201 Wellesley Court		10f. ZIP CODE: 21793	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: 1942 - 1964	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Civil Service	16b. KIND OF BUSINESS/INDUSTRY: DEPT. OF DEFENSE - NAVY
17. FATHER'S NAME (First, Middle, Last): John H. Crone		18. MOTHER'S NAME (First, Middle, Maiden Surname): Leila L. Snowden	
19a. INFORMANT'S NAME (Type/Print): N. Kenneth Crone		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5804 Planter's Ct., Frederick, Md. 21701	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens	20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Sandra L. Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral HOme, 1621 Opossumtown Pike, Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. METASTATIC PROSTATE CANCER WITH BONY	
DUE TO (OR AS A CONSEQUENCE OF):	METASTASIS.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one). HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Anusha Belami MD	29c. LICENSE NUMBER: D 26137.	29d. DATE SIGNED (Month, Day, Year) ▶ 12/24/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 198 Thomas Johnson Drive, Suite 104, Frederick, MD-21701.

31. DATE FILED (Month, Day, Year): DEC 27 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37603

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Reno Thomas Clingan
2. DATE OF DEATH — MONTH: December DAY: 7 YEAR: 1989
3. TIME OF DEATH: 2149 M
4. SOCIAL SECURITY NUMBER: 214-10-1755
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): May 9, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 14 Franklin Street
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Shovel Operator
16b. KIND OF BUSINESS/INDUSTRY: Quarry Operation
17. FATHER'S NAME (First, Middle, Last): Charles Edmund Clingan
18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie May Tinney
19a. INFORMANT'S NAME (Type/Print): Mrs. Bonnie C. King
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7934 McKaig Road, Frederick, Maryland 21701
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery
20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Sha M00255
22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home, 106 East Church St., Frederick, MD. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CHF (Pulmonary Edema) due to	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Mitral Regurgitation	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. COPD	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Atherosclerosis mild to moderate, involving coronary, renal, + aorta arteries
Previous RUL Lung Cancer resected 1985, LUL Lung Cancer Resected 9/89 (Johns Hopkins Hosp, Th...)

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James S. Grissom M.D.
29c. LICENSE NUMBER: D 21944
29d. DATE SIGNED (Month, Day, Year): ▶ 12/9/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JAMES S. GRISSOM M.D. 1475 TANEY AVE, SUITE 204, FREDERICK, MD.
31. DATE FILED (Month, Day, Year): DEC 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson Randall

DHMH-18 Rev 1/89

89 37604

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Clarabelle Ann COLLINS				2. DATE OF DEATH MONTH 12 DAY 1 YEAR 89		3. TIME OF DEATH 4:27 M
4. SOCIAL SECURITY NUMBER 214-10-4586	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) May 9, 1910	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 32 South Jefferson Street		10f. ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lab Technician	16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Charles Nichols		18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Ann Derr	
19a. INFORMANT'S NAME (Type/Print) Mrs. Ruth Ann Bredden	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8220 Greenvale Drive, Frederick, Maryland 21701		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Saint John's Catholic Cemetery	20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Keith Lynn Roberson M00706	22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, MD. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Amyloid Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER MD	29c. LICENSE NUMBER D20721	29d. DATE SIGNED (Month, Day, Year) ▶ 12/1/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey A. Cowen MD 310 W. 5th St Frederick MD 21701		
31. DATE FILED (Month, Day, Year) 12/11 DEC 04 1989	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

/2

89 37605

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Lewis Edward Crutchley, SR. / LEWIS EDWARD CRUTCHLEY, SR.			2. DATE OF DEATH MONTH 12 DAY 10 YEAR 89	3. TIME OF DEATH 1:17 P M
4. SOCIAL SECURITY NUMBER 217-10-9655	5. SEX 1 X M 2 ☐ F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) 10/24/13	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	

RESIDENCE OF DECEDENT

10a. STATE MD	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER 500 South Market Street		10f. ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 9th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired Carpenter	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Francis Marion Crutchley, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Rodgers	
19a. INFORMANT'S NAME (Type/Print) Nellie Mae Knill Crutchley	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 500 South Market St. Frederick, MD 21701		
20a. METHOD OF DISPOSITION 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery	20c. LOCATION — City or Town, State Frederick, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Robert E. Dailey Jr.	22. NAME AND ADDRESS OF FACILITY Robert E. Dailey & Son Funeral Homes PA 1201 N. Market St. Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIO pulmonary ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Edward P. Riuli MD	29c. LICENSE NUMBER MD D36649	29d. DATE SIGNED (Month, Day, Year) ▶ 12/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Edward P. Riuli MD 310 W. 9th St. Frederick, MD 21701

31. DATE FILED (Month, Day, Year) DEC 12 1989	32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 37606

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anthony Cincotta			2. DATE OF DEATH (Month, Day, Year): 12 03 89	3. TIME OF DEATH: 4:11 P M
4. SOCIAL SECURITY NUMBER: 710-09-7448	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): 3-6-06	8. BIRTHPLACE (State or Foreign Country): Baltimore, MD
9a. FACILITY NAME (If not institution, give street and number): 26 W Potomac St		9b. CITY, TOWN OR LOCATION OF DEATH: Brunswick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: 26 W Potomac St.	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 26 W Potomac	10f. ZIP CODE: 21716	10g. CITIZEN OF WHAT COUNTRY? USA	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Realtor	16b. KIND OF BUSINESS/INDUSTRY: Self-Employed
17. FATHER'S NAME (First, Middle, Last): Salvatore Pasquale Cincotta		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Maria Palmisano
19a. INFORMANT'S NAME (Type/Print): S. Jeanette Cincotta	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26 West Potomac St., Brunswick, Maryland 21716	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Cathedral Cemetery	20c. LOCATION — City or Town, State: Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams / Barbara A. Williams, Funeral Dir.	22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home, 100 Petersville Rd., Brunswick, Md. 21716	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 8 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
[X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible], MD	29c. LICENSE NUMBER: D35553	29d. DATE SIGNED (Month, Day, Year): 12/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Judith L. Pasierb, 620 9th Ave Brunswick, MD 21716		
31. DATE FILED (Month, Day, Year): DEC 19 1989	32. REGISTRAR'S SIGNATURE: [illegible]	

OHMH-15 Rev 1/89

89 37607

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Forrest Harding CHRISTIANSON
2. DATE OF DEATH (Month, Day, Year): 11 11 89
3. TIME OF DEATH: 2300 M
4. SOCIAL SECURITY NUMBER: 475-18-6237
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): June 9, 1922
8. BIRTHPLACE (State or Foreign Country): Minnesota
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7415 Hillside Drive
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: W.W. II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): District Representative
16b. KIND OF BUSINESS/INDUSTRY: Construction Equipment
17. FATHER'S NAME (First, Middle, Last): Martin Christianson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Clara Larsen
19a. INFORMANT'S NAME (Type/Print): Mrs. Doris Christianson
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7415 Hillside Drive, Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Evergreen Cemetery
20c. LOCATION — City or Town, State: Gettysburg, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allan H Ruby M00703
22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sepsis etio ?
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. ? Lymphoma in liver
DUE TO (OR AS A CONSEQUENCE OF):
c. Gingival Lymphoma
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Hyper tension

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D14C2C
29d. DATE SIGNED (Month, Day, Year): ▶ 11/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P.A. Raugh MD 501 W. Second St Frederick MD
31. DATE FILED (Month, Day, Year): NOV 13 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

89 37608

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Carter	2. DATE OF DEATH (Month, Day, Year): 12 15 89	3. TIME OF DEATH: 4:30 PM	
4. SOCIAL SECURITY NUMBER: 217-46-8955	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 41 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-16-1948
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): 15410 BERRYVILLE ROAD	9b. CITY, TOWN OR LOCATION OF DEATH: GERMANTOWN	9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT			
10a. STATE: MD.	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GERMANTOWN	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 15410 BERRYVILLE ROAD	10f. ZIP CODE: 20874	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCK DRIVER	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): WALTER CARTER	18. MOTHER'S NAME (First, Middle, Maiden Surname): HELEN E. REED		
19a. INFORMANT'S NAME (Type/Print): HELEN E. CARTER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15410 BERRYVILLE RD - GERMANTOWN, MD 20874		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DARNESTOWN PRESBY. CEMETERY	20c. LOCATION — City or Town, State: DARNESTOWN, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ WM C Hilton	22. NAME AND ADDRESS OF FACILITY: HILTON FUNERAL HOME 22111 BEALLSVILLE RD. DARNESVILLE, MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary arteriosclerosis.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D08546	▶ 12-16-89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 19 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37609

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY CAMPBELL				2. DATE OF DEATH (Month, Day, Year): December 18, 1989	3. TIME OF DEATH: 11:40 a.m
4. SOCIAL SECURITY NUMBER: 216-14-5062	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-10-1900	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: ~~County~~ Calvert	10c. CITY, TOWN OR LOCATION: Huntingtown			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3371 Holland Cliffs Road		10f. ZIP CODE: 20639		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: None			
17. FATHER'S NAME (First, Middle, Last): Lincoln Ayres		18. MOTHER'S NAME (First, Middle, Maiden Surname): Flora Israel			
19a. INFORMANT'S NAME (Type/Print): Jack C. Campbell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 15752 Smith Road Thurmont, Maryland 21788			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): Entombment		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mausoleum Resthaven Mem. Gardens		20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert E. Dailey Jr.		22. NAME AND ADDRESS OF FACILITY: ROBERT .E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. UPPER GI BLEED

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

ALZHEIMERS

ASCVD

H/O RECURRENT ABSCESS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER

29c. LICENSE NUMBER: D32171

29d. DATE SIGNED (Month, Day, Year): ▶ 12/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Richard L. Gough, M.D. 19 Frederick Street Walkersville, Md. 21793

31. DATE FILED (Month, Day, Year): DEC 19 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

89 37610

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Edwin CREAGER			2. DATE OF DEATH (Month, Day, Year): December 23, 1989	3. TIME OF DEATH: 9 55 M
4. SOCIAL SECURITY NUMBER: 215-20-7999	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 64 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Oct. 20, 1925	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Smithsburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Route 3, Box 38		10f. ZIP CODE: 21783	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0-12; College (1-4 or 5+): 5+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Lawyer	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Charles E. Creager	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Edith Bloyer
19a. INFORMANT'S NAME (Type/Print): Mrs. Dixie C. Creager	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 3, Box 38, Smithsburg, Maryland 21783

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery	20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich	22. NAME AND ADDRESS OF FACILITY: Minnich Funeral Home, 415 E. Wilson Blvd., Hagerstown, MD 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Myocardial Infarction	18 hrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Obstruction Pulmonary Disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W Ditto III	29c. LICENSE NUMBER: Do 1062	29d. DATE SIGNED (Month, Day, Year): ▶ Dec 26, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward Ditto, III, 217 W. Washington St., Hagerstown, Md. 21740

31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37611

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARION LORETTO Clark
2. DATE OF DEATH (Month, Day, Year): 12 20 89
3. TIME OF DEATH: 10:05 Am M
4. SOCIAL SECURITY NUMBER: 216-44-9045
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 96 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): 7 7 1893
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Wesleyan Health Care Center
9b. CITY, TOWN OR LOCATION OF DEATH: Denton
9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Talbot
10c. CITY, TOWN OR LOCATION: Queen Anne
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Talbot Street
10f. ZIP CODE: 21657
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H.S.grad. College (1-4 or 5+): 2 yrs. Approx.
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Postmistress
16b. KIND OF BUSINESS/INDUSTRY: Communications
17. FATHER'S NAME (First, Middle, Last): Charles Rhodes
18. MOTHER'S NAME (First, Middle, Maiden Surname): Nannie Lee Price
19a. INFORMANT'S NAME (Type/Print): Mary Greiner
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Queen Anne, Maryland 21657
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Spring Hill Cemetery
20c. LOCATION — City or Town, State: Easton, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph L. Moore
22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. Denton, Maryland 21629

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pyelonephritis
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James Sikes MD
29c. LICENSE NUMBER: D 31376
29d. DATE SIGNED (Month, Day, Year): ▶ 12-20-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Sikes MD PO Box 660 Denton Md
31. DATE FILED (Month, Day, Year): DEC 21 '89
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Orig. lost DVR,FilmG686 4/3/92 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37611

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GORDON MARSHALL BEADS, JR.
2. DATE OF DEATH (Month, Day, Year): 6 2 89
3. TIME OF DEATH: 9:30 PM
4. SOCIAL SECURITY NUMBER: 216-78-5005
5. SEX: 1 X M 2 ☐ F
6. AGE (In yrs. last birthday): 29 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 2-25-1960
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 2840 ROUND ROAD
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore
9c. COUNTY OF DEATH:

RESIDENCE OF DECEDENT

10a. STATE: Md
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: BALTIMORE
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 2516 SALERNO PLACE
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES:
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LABORER
16b. KIND OF BUSINESS/INDUSTRY: Building
17. FATHER'S NAME (First, Middle, Last): GORDON M. BEADS SR.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Shirley ROGERS
19a. INFORMANT'S NAME (Type/Print): Shirley BEADS
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2516 SALERNO Place BALTO MD 21230
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify):
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): CEDAR Hill Cemetery
20c. LOCATION — City or Town, State: A.A. County / Balto MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Herbert E. Nutter
22. NAME AND ADDRESS OF FACILITY: NUTTER FUNERAL HOME INC / Balto MD 2501 G WYNNS Falls Parkway 21216

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Narcotic intoxication Complicating
DUE TO (OR AS A CONSEQUENCE OF): Bronchopneumonia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify): Scene
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 X Could not be Determined
28a. DATE OF INJURY (Month, Day, Year): unknown
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED: unknown
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Found: House
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Found: 2840 Round Rd. Balt City Md.

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: OCME
29d. DATE SIGNED (Month, Day, Year): ▶ 6-3-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D. 111 Penn Street Baltimore, MD 21201
31. DATE FILED (Month, Day, Year): JUN 21 1989
32. REGISTRAR'S SIGNATURE:

89 37612

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Willis Cottman			2. DATE OF DEATH (Month, Day, Year): December 29 1989	3. TIME OF DEATH: 0430 M
4. SOCIAL SECURITY NUMBER: 215-26-4030	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8-21-26	8. BIRTHPLACE (State or Foreign Country): M.D.
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: M.D.	10b. COUNTY: ~~Worcester~~ Wicomico	10c. CITY, TOWN OR LOCATION: Salisbury M.D.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt2. Box 748 Purnell Street		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY? U.S. A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Blk
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired	16b. KIND OF BUSINESS/INDUSTRY: Perdue	
17. FATHER'S NAME (First, Middle, Last): Willis Cottman Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Cottman	
19a. INFORMANT'S NAME (Type/Print): Mamie E. Cottman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 748 Purnell St. Salisbury, 21809	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Spring Hill Cemetery	20c. LOCATION — City or Town, State: Salisbury M.D. PoB 1574	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell A. Fooks		22. NAME AND ADDRESS OF FACILITY: Fooks Funeral Home Salisbury 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Pulmonary emphysema
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Arteriosclerotic Heart Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.	29c. LICENSE NUMBER: D27670	29d. DATE SIGNED (Month, Day, Year): ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): D. C. M. EVANGELISTA	105 Pine Bluff Road Salisbury MD 21801	
31. DATE FILED (Month, Day, Year): JAN 3 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 37613

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph W. Deadrick
2. DATE OF DEATH: MONTH 11 DAY 29 YEAR 89
3. TIME OF DEATH: 3:27P M
4. SOCIAL SECURITY NUMBER: 213-24-8014
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): 6/26/28
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Greater LAUREL Bowsville Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: LAUREL
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Prince Georges
10c. CITY, TOWN OR LOCATION: LAUREL
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 805 8th ST. APT. T1
10f. ZIP CODE: 20702
10g. CITIZEN OF WHAT COUNTRY?: U.S.
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SAFEWAY FOOD INC.
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): RAYMOND M. DEADRICK
18. MOTHER'S NAME (First, Middle, Maiden Surname): JUANITA BROWN LEE
19a. INFORMANT'S NAME (Type/Print): STEPHEN DEADRICK
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12183 OVERLOOK DR, MONROVIA MD. 21770
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Monocacy Cemetary
20c. LOCATION — City or Town, State: Beallsville, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Willi D. Hilton
22. NAME AND ADDRESS OF FACILITY: HILTON FUNERAL HOME 22111 Beallsville Rd. BARNESVILLE MD.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. MALIGNANT VENTRICULAR ARRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF):
b. CONGESTIVE CARDIOMYOPATHY
DUE TO (OR AS A CONSEQUENCE OF):
c. ARTERIO SCLEROTIC HEART DISEASE,
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
CHRONIC ALCOHOL ABUSE,

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA | OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 6 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): 10/29/89
28b. TIME OF INJURY: 3:27 M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED:
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Arvind M. Mehta, MD,
29c. LICENSE NUMBER: D 27366
29d. DATE SIGNED (Month, Day, Year): ▶ 11/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARVIND M. MEHTA 7100 BALTIMORE AVE. #509, COLLEGE PARK, MD 20740
31. DATE FILED (Month, Day, Year): DEC 01 1989
32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

89 3713

89 37614

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Francis Laverne Dickensheets			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH: 11:20 P M
4. SOCIAL SECURITY NUMBER: 215-20-9482	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 23, 1924	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7205 Linganore Road		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 6 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Concrete/Home Improve.	16b. KIND OF BUSINESS/INDUSTRY: Contracting	
17. FATHER'S NAME (First, Middle, Last): Howard Raymond Dickensheets		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nora Isabelle Hahn	
19a. INFORMANT'S NAME (Type/Print): Mrs. Pauline C. Dickensheets		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7205 Linganore Road, Frederick, Maryland 21701	
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Frederick Memorial Park	20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Keith Lynn Roberson M00706		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D30721	▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey H Lowe MD 310 W 5th St. Frederick MD 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 1989	Julia Davidson-Randall

DHMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37615

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Edward DAVIS (Charles E Davis)			2. DATE OF DEATH (Month, Day, Year): December 30, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 216-30-3629	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 55 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 23, 1934	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Clear Spring	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Route 2, Box 102, Boyd Road		10f. ZIP CODE: 21722	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): bus driver	16b. KIND OF BUSINESS/INDUSTRY: schools	
17. FATHER'S NAME (First, Middle, Last): Charles W. Davis		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie Mae Heil	
19a. INFORMANT'S NAME (Type/Print): Esta Davis		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Box 102, Boyd Rd., Clear Spring, Md. 21722	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Manor Cemetery	20c. LOCATION — City or Town, State: Fairplay, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich		22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Ventricular Fibrillation	Min
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acute Myocardial Infarction	4 days
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Asthma

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles Spencer M.D.	29c. LICENSE NUMBER: D11133	29d. DATE SIGNED (Month, Day, Year): ▶ Jan 1 1990	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles C. Spencer 1198 Kealy Ave Hagerstown Md 21740			
31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Randall		

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37616

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elizabeth Kathryn DUDLEY						2. DATE OF DEATH (Month, Day, Year): December 27, 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 212-38-7565	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): April 20, 1909	8. BIRTHPLACE (State or Foreign Country): California
9a. FACILITY NAME (If not institution, give street and number): 177 Greenberry Road			9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown				9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 177 Greenberry Rd.	10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Education
17. FATHER'S NAME (First, Middle, Last): Samuel Otis Matthews, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura Agnes Lewis	
19a. INFORMANT'S NAME (Type/Print): Robert E. Dudley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 177 Greenberry Rd. Hagerstown, MD 21740	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery	20c. LOCATION — City or Town, State: Hagerstown, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: OSBORNE FUNERAL HOMES P.O. Box # 348 Williamsport, MD 21795	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. G.I. Bleeding	days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Alzheimer's Disease	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atherosclerosis	years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 5 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D/12606	29d. DATE SIGNED (Month, Day, Year): ▶ December 28, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Howard N. Weeks, M.D., 580 Nothern Avenue, Hagerstown, Maryland 21740

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-15 Rev 1/89

89 37617

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joyce H. Elliott			2. DATE OF DEATH (Month, Day, Year): 12 23 89	3. TIME OF DEATH: 0900 M
4. SOCIAL SECURITY NUMBER: 218-24-5370A	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07-02-29	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 612 Bowman Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury		9c. COUNTY OF DEATH: Wicomico
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 612 BOWMAN DRIVE		10f. ZIP CODE: 21801		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 YEARS; College (1-4 or 5+): ---	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): SECRETARY	16b. KIND OF BUSINESS/INDUSTRY: COASTAL BOARD		
17. FATHER'S NAME (First, Middle, Last): JOSHUA RAYMOND HOLLOWAY		18. MOTHER'S NAME (First, Middle, Maiden Surname): LENA MAE FARLOW		
19a. INFORMANT'S NAME (Type/Print): ROBERT ELLIOTT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): N. PARK GARDENS, APT. B1, SALISBURY. MD 21801			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WICOMICO MEMORIAL PARK	20c. LOCATION — City or Town, State: SALISBURY , MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Holloway	22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Chronic Alcoholism

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29e. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John T. Bulkeley Deputy M.E.	D03599	▶ 12-23-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John T. Bulkeley, M.D. - Salisbury, Maryland

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	

16

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37618

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rose "Renee" Eisenberg
2. DATE OF DEATH (Month, Day, Year): 12 23 89
3. TIME OF DEATH: 11:20A
4. SOCIAL SECURITY NUMBER: 130-20-2008
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 82 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): 9-5-1907
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): Berlin Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Berlin, MD
9c. COUNTY OF DEATH: Worcester

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Worcester
10c. CITY, TOWN OR LOCATION: Berlin, Md
10d. INSIDE CITY LIMITS? ☒ 1 YES 2 ☐ NO
10e. STREET AND NUMBER: 2901 Balto.Ave. O.City, MD
10f. ZIP CODE: 21842
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4 or 5+): UNK
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary
16b. KIND OF BUSINESS/INDUSTRY: Hotel
17. FATHER'S NAME (First, Middle, Last): Issac Taustin
18. MOTHER'S NAME (First, Middle, Maiden Surname): Fanny Silber Taustin
19a. INFORMANT'S NAME (Type/Print): SAM TAUSTIN
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX 500, OCEAN CITY, MD 21842
20a. METHOD OF DISPOSITION: 12/27/89 — 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BETH ISRAEL CEMETERY
20c. LOCATION — City or Town, State: SALISBURY, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. R. Holloway
22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA, 501 SNOW HILL RD, SALISBURY, MD 21801

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D02026
29d. DATE SIGNED (Month, Day, Year): 12-23-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Federico G. Arthes
31. DATE FILED (Month, Day, Year): DEC 27 '89
32. REGISTRAR'S SIGNATURE

OHMH-16 Rev 1/89

89 37619

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Herbert ECKER, Jr.

2. DATE OF DEATH (Month, Day, Year): December 25, 1989

3. TIME OF DEATH: M

4. SOCIAL SECURITY NUMBER: 215 32 1173

5. SEX: 1 ☐ M 2 ☒ F — male

6. AGE (In yrs. last birthday): 60 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): Aug. 18, 1929

8. BIRTHPLACE (State or Foreign Country): Md. Carroll Co..

9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown

9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Washington

10c. CITY, TOWN OR LOCATION: Hagerstown

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: Route 40

10f. ZIP CODE: 21740

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO
IF YES, GIVE WAR OR DATES: 1955-1963

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12):
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.):

16b. KIND OF BUSINESS/INDUSTRY: railroad

17. FATHER'S NAME (First, Middle, Last): Charles Herbert Ecker

18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertie Owings

19a. INFORMANT'S NAME (Type/Print): Pearl M. Ecker

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 40, Hagerstown, Md. 21740

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park

20c. LOCATION — City or Town, State: Hagerstown, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnick

22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME
415 E. Wilson Blvd., Hagerstown, Md. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Pulmonary hemorrhage	2 hrs.
DUE TO (OR AS A CONSEQUENCE OF): b.	Metastatic Carcinoma of oropharynx	6 mos
DUE TO (OR AS A CONSEQUENCE OF): c.	Carcinoma of oropharynx	1 yr
DUE TO (OR AS A CONSEQUENCE OF): d.		

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Tracheal Esophageal obstruction

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Thomas V Craig MD

29c. LICENSE NUMBER:

29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas V Craig MD 208 E. Antietam St. Hagerstown MD 21740

31. DATE FILED (Month, Day, Year): DEC 28 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 3Jel3

UNKNOWN #89-249

89 37620

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2-5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Howard Florence				2. DATE OF DEATH (Month / Day / Year): 12 / 27 / 89	3. TIME OF DEATH: 2:40 P M
4. SOCIAL SECURITY NUMBER: 229-46-2680	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 57 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): October 23, 1932	8. BIRTHPLACE (State or Foreign Country): N.C.
9a. FACILITY NAME (If not institution, give street and number): 3100 Branch Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Temple Hills		9c. COUNTY OF DEATH: Prince George's Co.

RESIDENCE OF DECEDENT

10a. STATE: D.C.	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: Washington	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2901 - 7th Street, S.E.		10f. ZIP CODE: 20032	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Barber	16b. KIND OF BUSINESS/INDUSTRY: Johnnie's Barber Shop	
17. FATHER'S NAME (First, Middle, Last): James Florence		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Gentery	
19a. INFORMANT'S NAME (Type/Print): Kathryn Florence		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3398 Curtis Drive #1 Suitland, MD 20746	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lincoln Memorial Cemetery	20c. LOCATION — City or Town, State: Suitland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Julia P. Marshall		22. NAME AND ADDRESS OF FACILITY: Marshall's Funeral Home 4217-9th. St. NW Washington, D.C. 20011	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Exposure to cold	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify): Scene		
27. MANNER OF DEATH: 1 [ ] Natural [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-27-89	28b. TIME OF INJURY: 2:37 P M	28c. INJURY AT WORK? 1 [ ] YES [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Found exposed to cold weather
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): outside of ballfield			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 3100 Branch Avenue, Temple Hills, P.G. Co., MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D., Assistant 111 Penn Street, Baltimore, MD 21201		
31. DATE FILED (Month, Day, Year): JAN 17 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

DHMH-16 Rev 1/89

89 3760

89 37621

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RAYMOND FENNEMAN		2. DATE OF DEATH: MONTH DEC DAY 23 YEAR 1989	3. TIME OF DEATH: 11 29 A M
4. SOCIAL SECURITY NUMBER: 336-03-2192	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-25-1912
8. BIRTHPLACE (State or Foreign Country): ILLINOIS			
9a. FACILITY NAME (If not institution, give street and number): SHADY GROVE ADVENTIST	9b. CITY, TOWN OR LOCATION OF DEATH: ROCKVILLE	9c. COUNTY OF DEATH: MONTGOMERY	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: GAITHERSBURG	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 28 DALAMAR ST. #2	10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY?: U.S.A	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: W.W. II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 H; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CHIEF PETTY OFFICER	16b. KIND OF BUSINESS/INDUSTRY: NAVY -- U.S. GOV'T.	
17. FATHER'S NAME (First, Middle, Last): MAXIMILLION FENNEMAN	18. MOTHER'S NAME (First, Middle, Maiden Surname): ANNA PHLUG		
19a. INFORMANT'S NAME (Type/Print): BARBARA M FENNEMAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 DALAMAR ST. GAITHERSBURG MD 20877		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SMITHSBURG	20c. LOCATION — City or Town, State: SMITHSBURG, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ W.C. Hilton	22. NAME AND ADDRESS OF FACILITY: HILTON FUNERAL HOME 22111 BEALLSVILLE RD, BARNESVILLE MD		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. SEPTIC SHOCK	1 DAY
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST	b. SUSPECTED INTESINAL ISCHEMIA	1 DAY
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CHRONIC OBSTRUCTIVE LUNG DISEASE, MYLODYSPLASIA, VENTRICULAR ARRHYTHMIAS

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ ND | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Steven T. Kariya — MD	D36252	▶ 12/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEVEN T. KARIYA, MD 4701 RANDOLPH RD #63 ROCKVILLE MD 20852

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37622

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Carl Christian FINK

2. DATE OF DEATH (Month, Day, Year): December 27, 1989

3. TIME OF DEATH: 3:15 AM M

4. SOCIAL SECURITY NUMBER: 214-10-1511

5. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): Nov. 21, 1917

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 207 Magnolia Avenue

9b. CITY, TOWN OR LOCATION OF DEATH: Frederick

9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Frederick

10c. CITY, TOWN OR LOCATION: Frederick

10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER: 207 Magnolia Ave.

10f. ZIP CODE: 21701

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: 1943-1946

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales

16b. KIND OF BUSINESS/INDUSTRY: Clothing Retail

17. FATHER'S NAME (First, Middle, Last): John Sherman Fink

18. MOTHER'S NAME (First, Middle, Maiden Surname): Evie Elsroad

19a. INFORMANT'S NAME (Type/Print): Mrs. Louise Fink

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 207 Magnolia Ave., Frederick, Md. 21701

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery

20c. LOCATION — City or Town, State: Frederick, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Graf M00255

22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma of lung with liver

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. and bone metastasis

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Empty sella
Coronary artery disease with old myocardial infarction

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Austin Pearre

29c. LICENSE NUMBER: D09689

29d. DATE SIGNED (Month, Day, Year): ▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Austin A. Pearre, Jr., M.D., 300 West Ninth Street, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): DEC 28 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

Richard E. Hoy

89 37623

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Esther Maria Frye			2. DATE OF DEATH (Month, Day, Year): 11 22 89	3. TIME OF DEATH: 11:16 AM
4. SOCIAL SECURITY NUMBER: 214-48-4951	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 03/16/1896	8. BIRTHPLACE (State or Foreign Country): Frederick County
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Walkersville		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7900 Miles Lane		10f. ZIP CODE: 21793		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Homemaker	
17. FATHER'S NAME (First, Middle, Last): William W. Utterback		18. MOTHER'S NAME (First, Middle, Maiden Surname): Emma W. Thomas		
19a. INFORMANT'S NAME (Type/Print): Charles W. Frye		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 750 Reed Canal Rd. #19, South Dayton, FL 32119		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Hebron Cemetery		20c. LOCATION — City or Town, State: Winchester, VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams, Funeral Dir.		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home, 100 Petersville Rd., Brunswick, MD 21716		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Chronic cardiac arrhymia	2 years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	DUE TO (OR AS A CONSEQUENCE OF): b. First degree A-V Block	2 years
	DUE TO (OR AS A CONSEQUENCE OF): c. Occasional premature ventricular beat	9 mos.
	DUE TO (OR AS A CONSEQUENCE OF): d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
LeRoy T. Davis MD	DO 1902	▶ 11/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LeROY T. DAVIS, M.D., 901 Toll House Ave, Frederick, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 05 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

89 37624

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie Edith Fogle (Marie Elizabeth Fogle)			2. DATE OF DEATH: MONTH 12 DAY 14 YEAR 89	3. TIME OF DEATH: 5:15 P M
4. SOCIAL SECURITY NUMBER: 217-12-1630	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In last birthday): 65 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7/20/24	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1323 Taney Avenue		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse's Aide	16b. KIND OF BUSINESS/INDUSTRY: Hospital	
17. FATHER'S NAME (First, Middle, Last): Charles Henry Leppo		18. MOTHER'S NAME (First, Middle, Maiden Surname): Unknown	
19a. INFORMANT'S NAME (Type/Print): Evelyn Cook		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1323 Taney Avenue, Frederick, Maryland 21701	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Monocacy Cemetery	20c. LOCATION — City or Town, State: Beallsville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Honda L Lemmon		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Atherosclerotic Cardiovascular Disease	7yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER: Andrew Zaddick Acting Deputy Medical Examiner		29c. LICENSE NUMBER: D35164	29d. DATE SIGNED (Month, Day, Year): ▶ 12-14-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Andrew Zaddick, Jr, MD 15 E Frederick St Walkersville MD 21793			
31. DATE FILED (Month, Day, Year): DEC 18 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

89 37625

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HELEN S. Freeman
2. DATE OF DEATH — MONTH: 12 DAY: 16 YEAR: 89
3. TIME OF DEATH: 2:15 PM
4. SOCIAL SECURITY NUMBER: 218-20-3019
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01-20-13
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Mallard Bay Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge, Md. 21613
9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Dorchester
10c. CITY, TOWN OR LOCATION: Cambridge
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER:
10f. ZIP CODE: 21613
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Linwood Single
18. MOTHER'S NAME (First, Middle, Maiden Surname): Lillian Wilmur
19a. INFORMANT'S NAME (Type/Print): William Single
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO Box 593 Preston, Md. 21655
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Carmichael
20c. LOCATION — City or Town, State: Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith
22. NAME AND ADDRESS OF FACILITY: Bennie Smith Services PO Box 928 Hurlock, Md. 21643

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Viral Syndrome c Pulmonary Congestion — 5 days
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
OBS, Renal failure, ASCVD, anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Hubert K Fiery MD
29c. LICENSE NUMBER: D22773
29d. DATE SIGNED (Month, Day, Year): ▶ 12/16/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HUBERT K FIERY MD 503 BYRNE ST CAMBRIDGE Md 21613
31. DATE FILED (Month, Day, Year): JAN 12 '90
32. REGISTRAR'S SIGNATURE: Davidson-Randall

DHMH-15 Rev 1/89

89 3762S

89 37626

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Girl Fisher / Latasha A. Fisher-T WA BE. BoT Ty Showell H			2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 89	3. TIME OF DEATH: 2242 M	
4. SOCIAL SECURITY NUMBER: 900-19-6700	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS 1 — IF UNDER 24 HRS.: HOURS — MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-29-89	8. BIRTHPLACE (State or Foreign Country): Salisbury	
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Wico	10c. CITY, TOWN OR LOCATION: Salisbury, Md.	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: Rt#2 Heane Lane - Salisbury		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEOENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS OECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Blk

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Ricky Fisher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Louise Showell	
19a. INFORMANT'S NAME (Type/Print): Betty Louise Showell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R#2 Heane Lane - Salisbury, Md. 21801		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶	22. NAME AND ADDRESS OF FACILITY: Lewis N. Watson Funeral Home, Salisbury, West Rd.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. EXTREME PREMATURITY	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	28. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	26a. DATE OF INJURY (Month, Day, Year) — 26b. TIME OF INJURY M — 26c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	26d. DESCRIBE HOW INJURY OCCURED
	26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John J Farley MD	29c. LICENSE NUMBER: D32226	29d. DATE SIGNED (Month, Day, Year) ▶ 12/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN FARLEY MD 20640 PRINCESS ANNE, MD		
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3, and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37627

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Latoya M. Fisher TWB ~~Baby Girl~~ Fisher Betty Showell	2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 89	3. TIME OF DEATH: 2354 M		
4. SOCIAL SECURITY NUMBER: 900-19-6701	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS 1 — IF UNDER 24 HRS.: HOURS — MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-29-89	8. BIRTHPLACE (State or Foreign Country): Salisbury
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND	9c. COUNTY OF DEATH: WICOMICO		

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Salisbury	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Rt 2 Hearne Lane - Salisbury	10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Blk

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 0 — College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): —	16b. KIND OF BUSINESS/INDUSTRY: —

17. FATHER'S NAME (First, Middle, Last): Ricky Fisher	18. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Louise Showell
19a. INFORMANT'S NAME (Type/Print): Betty Louise Showell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 2 Hearne Lane - Salisbury Md. 21801

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Acres Cemt.	20c. LOCATION — City or Town, State: Salisbury, Md. 21801
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶	22. NAME AND ADDRESS OF FACILITY: LEWIS N. WATSON Funeral Home Salisbury West Rd.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. EXTREME PREMATURITY	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John J Farley MD	29c. LICENSE NUMBER: D32226	29d. DATE SIGNED (Month, Day, Year) ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN FARLEY MD PO 640 PRINCESS ANNE, MD

31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE:

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37628

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed/filed in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): KATHRYN IRENE Fowler		2. DATE OF DEATH (Month, Day, Year): 12 28 89	3. TIME OF DEATH: 5:56 AM
4. SOCIAL SECURITY NUMBER: 214-22-9071	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 09/26/12
8. BIRTHPLACE (State or Foreign Country): MARYLAND			
9a. FACILITY NAME (If not institution, give street and number): Wesleyan Health Care Center	9b. CITY, TOWN OR LOCATION OF DEATH: Denton, MD	9c. COUNTY OF DEATH: CAROLINE	
RESIDENCE OF DECEDENT			
10a. STATE: MARYLAND	10b. COUNTY: CAROLINE	10c. CITY, TOWN OR LOCATION: DENTON	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 107 RANDOLPH STREET	10f. ZIP CODE: 21629	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): H.S.grad. College (1-4 or 5+): 2 yrs	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Medical	
17. FATHER'S NAME (First, Middle, Last): William Thomas Beauchamp	18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Brady Horsey		
19a. INFORMANT'S NAME (Type/Print): Betty Jean Bullock	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box 9-C, Denton, Maryland 21629		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Denton Cemetery	20c. LOCATION — City or Town, State: Denton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph Moore	22. NAME AND ADDRESS OF FACILITY: Moore Funeral Home, P.A. 25 2nd St. Denton, Md 21629		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Systemic lupus erythematosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Sepsis
Diabetes, mellitus
Atherosclerosis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	M		

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D35284	▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREA ALLEN POB 122 GOODSBORO MD 21636

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 3762

89 37629

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Sarah Green	Sarah Green	2. DATE OF DEATH MONTH 12 DAY 27 YEAR 89 (89)	3. TIME OF DEATH 9:15 A M (9:15 A M)	
4. SOCIAL SECURITY NUMBER: 209-12-3695	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-25-1916
8. BIRTHPLACE (State or Foreign Country): Maryland				
9a. FACILITY NAME (If not institution, give street and number): Dorchester General	9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge	9c. COUNTY OF DEATH: Dorchester		
RESIDENCE OF DECEDENT				
10a. STATE: PA	10b. COUNTY: Philadelphia	10c. CITY, TOWN OR LOCATION: Philadelphia	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO	
10e. STREET AND NUMBER: 4731 Upland St.	10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nursing	16b. KIND OF BUSINESS/INDUSTRY: Private Families		
17. FATHER'S NAME (First, Middle, Last): Bejamin H. Winchester	18. MOTHER'S NAME (First, Middle, Maiden Surname): Nolena Rodchester			
19a. INFORMANT'S NAME (Type/Print): Charlotte E. Butler	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd. 1 Box 54 Barclay, Md. 21607			
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rodchester Memorial	20c. LOCATION — City or Town, State: Ingleside, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bennie L. Smith	22. NAME AND ADDRESS OF FACILITY: Benny's Smith Services PO Box 928 Hurlock, Md. 21643			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Possible G I bleeding

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Possible G I bleeding

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Organic Brain Syndrome Seizure disorder Organic Brain Syndrom, Seizure Disorder (by history) History of Brain tumor (by history) History of Brain tumor.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Eyup Tanman, M.D.

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Eyup Tanman, M.D. 17 Franklin Street Cambridge Maryland 21613

31. DATE FILED (Month, Day, Year): JAN 11 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37630

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harvey L. GREEN, Sr.			2. DATE OF DEATH (Month, Day, Year): Dec. 24, 1989	3. TIME OF DEATH: 7:20 P. M
4. SOCIAL SECURITY NUMBER: 219-16-3262	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 26, 1905	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Citizens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Monrovia	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 12443 Fingerboard Road		10f. ZIP CODE: 21770	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Painter	16b. KIND OF BUSINESS/INDUSTRY: Board of Education		
17. FATHER'S NAME (First, Middle, Last): Lawrence W. Green		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel Cain		
19a. INFORMANT'S NAME (Type/Print): George W. Green	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8716 Main St., Damascus, Md. 20872			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Poplar Springs Cemetery	20c. LOCATION — City or Town, State: Poplar Springs, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth	22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIORESPIRATORY ARREST	10 min
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

- EMPHYSEMA
- DEMENTIA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year): N/A

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D 31912

29d. DATE SIGNED (Month, Day, Year): ▶ Dec. 26, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julio Menocal, M.D. Parkview Medical Center, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): DEC 26 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89 37631

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles E. Geisler
2. DATE OF DEATH: MONTH 12 DAY 01 YEAR 1989
3. TIME OF DEATH: 4:50A M
4. SOCIAL SECURITY NUMBER: 220-01-3751
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 29, 1917
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Perry Point VA Medical Center
9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point
9c. COUNTY OF DEATH: Cecil

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Cecil
10c. CITY, TOWN OR LOCATION: Perry Point
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: Veterans Administration Hospital
10f. ZIP CODE: 21902
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 4-28-1941 /4-15-1944
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Manufacturing
16b. KIND OF BUSINESS/INDUSTRY: Factory
17. FATHER'S NAME (First, Middle, Last): Glenn V. Geisler
18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna Helen McDonough
19a. INFORMANT'S NAME (Type/Print): Mr. Raymond E. Geisler
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4709 Araby Church Rd, Frederick, MD 21701
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens
20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Lynn Robeson M00706
22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA. Funeral Home 106 East Church St., Frederick, MD 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ca Colon

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? XX 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) XX 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ibrahim Bshara M.D.
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year): 12-1-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ibrahim Bshara M.D. VA Medical Center Perry Point Md. 21902

31. DATE FILED (Month, Day, Year): DEC 04 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall

DHMH-ta Rev t/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37632

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine Ellen Gosnell					2. DATE OF DEATH (Month, Day, Year): December 21, 1989	3. TIME OF DEATH: 8:30 pM
4. SOCIAL SECURITY NUMBER: 214-10-1416	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Oct. 4, 1905	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Vindobona Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Braddock Heights		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 1421 Taney Avenue			10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 / College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales		16b. KIND OF BUSINESS/INDUSTRY: Retail Stores	
17. FATHER'S NAME (First, Middle, Last): Charles Collier			18. MOTHER'S NAME (First, Middle, Maiden Surname): Nan Barger			
19a. INFORMANT'S NAME (Type/Print): Mr. Ralph C. Fry, Jr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8929 Yellow Springs Pike, Frederick, MD 21701			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery		20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Lyren Roberson M00706			22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ASPIRATION PNEUMONIA	1 WK
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: CEREBRAL VASCULAR ACCIDENT

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wayne Allgaier MD	29c. LICENSE NUMBER: D 16675	29d. DATE SIGNED (Month, Day, Year): Dec. 22, 1989	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wayne Allgaier, M.D., 4014 Mountville Road, Jefferson, Maryland 21755			
31. DATE FILED (Month, Day, Year): DEC 22 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

89 37633

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ARTHUR Arthur Roy Gardner GARDNER			2. DATE OF DEATH: MONTH 12 DAY 01 YEAR 89	3. TIME OF DEATH: 1725 M
4. SOCIAL SECURITY NUMBER: 258-52-1662	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 5-18-38	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): 7915 Runnymeade Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 7915 Runnymeade Drive		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: Viet Nam	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Colonel Army		16b. KIND OF BUSINESS/INDUSTRY: US Army
17. FATHER'S NAME (First, Middle, Last): Joseph Gardner		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eula Burke Gardner		
19a. INFORMANT'S NAME (Type/Print): Willie H. Gardner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7915 Runnymeade Drive, Frederick, MD 21701		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Westwood Cemetery		20c. LOCATION — City or Town, State: Fitzgerald, Ga.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. GUN SHOT WOUND — HEAD	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURRED
1 ☐ Natural 2 ☐ Accident 3 ☒ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert R Roberts MD	D0986T	▶ 12/01/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RRR ROBERTS MD 15W 7TH ST Frederick MD 21701-4599

31. DATE FILED (Month, Day, Year)	REGISTRAR'S SIGNATURE
DEC 04 1989	Julia Davidson-Randall

DNMN-16 Rev 1/89

89 37634

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. **IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Emil GOSSETT			2. DATE OF DEATH (Month, Day, Year): Dec. 11, 1989	3. TIME OF DEATH: 10:00 AM
4. SOCIAL SECURITY NUMBER: 126 -16-0142	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 1, 1926	8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 7416 Skyline Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 7416 Skyline Drive		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Vice President Sales	16b. KIND OF BUSINESS/INDUSTRY: McCall Pattern Company		
17. FATHER'S NAME (First, Middle, Last): Robert Gossett		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Bartel		
19a. INFORMANT'S NAME (Type/Print): Mrs. Joan Gossett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7416 Skyline Dr., Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory	20c. LOCATION — City or Town, State: Smithsburg, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Graf M00255		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	5 minutes
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	C.O.P.D. - m.i. Artery Disease	1973
c. DUE TO (OR AS A CONSEQUENCE OF):	Diabetes Mellitus	55 years
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

		24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Casper E. Cline III M.D.	29c. LICENSE NUMBER: D16428	29d. DATE SIGNED (Month, Day, Year): ▶ 12/11/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Casper E. Cline III 300WEST Ninth Street, Frederick, Md. 21701		
31. DATE FILED (Month, Day, Year): DEC 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37635

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES THOMAS GERRITY
2. DATE OF DEATH: MONTH 12 DAY 12 YEAR 89
3. TIME OF DEATH: 0630 M
4. SOCIAL SECURITY NUMBER: 082-54-9170
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 31 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 24, 1958
8. BIRTHPLACE (State or Foreign Country): New York
9a. FACILITY NAME (If not institution, give street and number): 6905 Double Brand Crt.
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 6905 Double Brand Crt.
10f. ZIP CODE: 21071
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Active Duty
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+): 2
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Soldier
16b. KIND OF BUSINESS/INDUSTRY: U.S. Army
17. FATHER'S NAME (First, Middle, Last): Fredrick E. Gerrity
18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva - Socha
19a. INFORMANT'S NAME (Type/Print): Eileen Gerrity
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6905 Double Brand Crt. Frederick, MD. 21071
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Arlington Nat'l Cemetery
20c. LOCATION — City or Town, State: Arlington, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Thomas S. Chambers # 670
22. NAME AND ADDRESS OF FACILITY: W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. STRANGULATION & Ligature

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert R R Roberts
29c. LICENSE NUMBER: D09867
29d. DATE SIGNED (Month, Day, Year): ▶ 12/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RR ROBERTS MD 15 W 7TH ST FREDERICK MD 21701-4599
31. DATE FILED (Month, Day, Year): DEC 14 1989
32. REGISTRAR'S SIGNATURE: Julia Robinson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37636

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH (Month, Day, Year)		3. TIME OF DEATH
V. H. Carlos		Gibson			Dec. 30, 1989		4:20PM M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
579-80-4009	1 ☒ M 2 ☐ F	70 YRS.			June 5, 1919		Wasington, D.C.
8a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH	
Bethesda Nursing Center			Bethesda			Montgomery	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
None	None	Washington, D.C.	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4626 Garfield Street, N.W.	20007	Peru

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☒ YES 2 ☐ NO Specify: Peru	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12	4	Foreign Service Officer	Peru Gov't.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Carlos Gibson	Mercedes Lira

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Florence Gibson	Same as #10

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Metropolitan Crematory	Alex., Va.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ James E. [illegible]	DeVol Funeral Home 2222 Wisc. Ave., N.W., Wash. D.C. 20007

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiec or reapiratory arreat, shock, or heart failure. List only one cause on aach line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate ceuse. Enter UNDERLYING CAUSE (Disease or injury that initiated evente resulting in death) LAST
b. Dementia

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other signifiicent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mary Restifo MD	DC 6165	▶ Dec. 30, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Mary Restifo, M.D., 3301 New Mexico Ave., N.W., Washington, D.C. 20016

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 4 '90	Julia Davidson-Randall

20

DHMH-18 Rev 1/89

89 3736

89 37637

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY M. GLENN (Mary Martha GLENN)			2. DATE OF DEATH: MONTH 12 DAY 24 YEAR 89	3. TIME OF DEATH: 8:30 P M
4. SOCIAL SECURITY NUMBER: 214-09-2766	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 2-15-95	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): COLTON VILLA		9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN		9c. COUNTY OF DEATH: WASHINGTON
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 715 Walnut St.		10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): stenographer		16b. KIND OF BUSINESS/INDUSTRY: furniture mfg.
17. FATHER'S NAME (First, Middle, Last): Daniel I. Kline			18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah V. Rohrer	
19a. INFORMANT'S NAME (Type/Print): Sonya M. Sabey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Route 2, Box 96B, Altus, Oklahoma 73521		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery		20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich		22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: senile dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Orreal md	29c. LICENSE NUMBER: D24457	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDUL WAHEED MD 1610 - OAK HILL AVE. HAGERSTOWN. MD		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-15 Rev 1/89

89 37638

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Florence Gantz			2. DATE OF DEATH (Month, Day, Year): 12 28 89		3. TIME OF DEATH: 6:05A M
4. SOCIAL SECURITY NUMBER: 217-30-6201	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 97 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-13-92	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Colton Villa Ctr.			9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington	
RESIDENCE OF DECEDENT						
10a. STATE: Md.	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown			10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO	
10e. STREET AND NUMBER: 11 W. Baltimore St.		10f. ZIP CODE: 21740			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Elem; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker			16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Richard Martin			18. MOTHER'S NAME (First, Middle, Maiden Surname): Matilda Johnson			
19a. INFORMANT'S NAME (Type/Print): Hazel M. Stewart		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11 W. Balto. St. Hagerstown, Md. 21740				
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Mem. Pk.			20c. LOCATION — City or Town, State: Hagerstown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Dennis L. Davis			22. NAME AND ADDRESS OF FACILITY: Watson Funeral Home-244 W. Bethel St. Hagerstown, Md. 21740			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Carcinoma of Colon

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]

29c. LICENSE NUMBER: D21457

29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Abdul Waheed, MD 1610- Oak Hill Ave. Hagerstown MD 21740

31. DATE FILED (Month, Day, Year): DEC 29 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37639

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GRACE KNOTTS GROFF		2. DATE OF DEATH (Month, Day, Year): DEC 25 1989	3. TIME OF DEATH: EST. 3A M
4. SOCIAL SECURITY NUMBER: 216-56-1504	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): est 80 87 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 02/13/02
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): 203 W. Central Avenue	9b. CITY, TOWN OR LOCATION OF DEATH: FEDERALSBURG	9c. COUNTY OF DEATH: CAROLINE	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 203 W. Central Avenue	10f. ZIP CODE: 21632	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 8+): 4 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Nurse	16b. KIND OF BUSINESS/INDUSTRY: Medical
17. FATHER'S NAME (First, Middle, Last): John Schlott		18. MOTHER'S NAME (First, Middle, Maiden Surname): Eva Rohrer Schlott Hamlin	
19a. INFORMANT'S NAME (Type/Print): Thomas Everngam, Esq.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): First & Market Sts., Denton, MD 21629	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Silver Spring Cem.	20c. LOCATION — City or Town, State: Silver Spring, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Eskow		22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	ACUTE
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ARTERIOSCLEROTIC CARDIOVASCULAR disease	chronic
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Christian E Jensen MD

29c. LICENSE NUMBER: D14664

29d. DATE SIGNED (Month, Day, Year): ▶ 12/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHRISTIAN E. JENSEN MD, BOX 690, DENTON MD 21629

31. DATE FILED (Month, Day, Year): DEC 29 '89

32. REGISTRAR'S SIGNATURE: Jisha Davidson-Randall

DHMH-18 Rev 1/89

89 37640

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HAROLD CLYDE HOLLINGER						2. DATE OF DEATH (Month, Day, Year): December 20, 1989	3. TIME OF DEATH: 5:30 aM
4. SOCIAL SECURITY NUMBER: 161-20-0477	5. SEX: XX M 2 ☐ F	6. AGE (In yrs. last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): June 29, 1927	8. BIRTHPLACE (State or Foreign Country): Penn.
9a. FACILITY NAME (If not institution, give street and number): 7821 Rocky Springs Road			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick			9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Frederick			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO	
10e. STREET AND NUMBER: 7821 Rocky Springs Road			10f. ZIP CODE: 21701			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Freight Agent			16b. KIND OF BUSINESS/INDUSTRY: Rail Road Chessie System	
17. FATHER'S NAME (First, Middle, Last): Frank Harris Hollinger						18. MOTHER'S NAME (First, Middle, Maiden Surname): Alla Belle Huff	
19a. INFORMANT'S NAME (Type/Print): Oneida Lavinia Rakes Hollinger			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7821 Rocky Springs Rd. Frederick, Md. 21701				
20a. METNOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery			20c. LOCATION — City or Town, State: Frederick, Md. 21701	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey			22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cancer of Pancreas	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Strokes

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 X NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ✓ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ✓ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ✓ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James A. Frizzell, M.D.	D16637	▶ 12-21-1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Frizzell, M.D. 915 Toll House Avenue Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 22 1989	Julia Davidson-Randall

DNMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37641

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Elizabeth HAHN / MARY Elizabeth HAHN				2. DATE OF DEATH (Month / Day / Year): 12 / 21 / 89	3. TIME OF DEATH: 1925 PM
4. SOCIAL SECURITY NUMBER: 220-26-5281	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 58 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-24-31	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK MD		9c. COUNTY OF DEATH: FREDERICK

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 5802 I Lantana Circle		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk	16b. KIND OF BUSINESS/INDUSTRY: Retail Department Store	
17. FATHER'S NAME (First, Middle, Last): Howard Tyeryar		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Yeager	
19a. INFORMANT'S NAME (Type/Print): Josoph S. Hahn Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5802 I Lantana Circle, Frederick, Md. 21701	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▸ Richard E. Graf M00255		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. *Metastatic Pancreatic Carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) F M H			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Carmen R Hernandez	MD D35271	▸ 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 310 West 9th ST Frederick Md 21701 CARMEN R HERNANDEZ

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 22 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Richard E. Hoff

89 37642

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLES SAYRE HOLMES Holmes Sayre Charles.		2. DATE OF DEATH (Month, Day, Year): 12 17 1989	3. TIME OF DEATH: 7:30 p. M
4. SOCIAL SECURITY NUMBER: 223-28-5234	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 66 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb/ 17 1923
8. BIRTHPLACE (State or Foreign Country): New Hampshire			
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 17 So. Jefferson St.	10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES: W W II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Material mgmt. control	16b. KIND OF BUSINESS/INDUSTRY: Watkins Johnson & Data Card	
17. FATHER'S NAME (First, Middle, Last): Charles E. Holmes		18. MOTHER'S NAME (First, Middle, Maiden Surname): Genivieve Hazard	
19a. INFORMANT'S NAME (Type/Print): Peggy H. Holmes	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 17 So. Jefferson St., Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Utica Cemetery	20c. LOCATION — City or Town, State: Utica MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Glenda L Lemmon	22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home 1621 Opossumtown Pike Frederick Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiogenic shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. massive myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: K. Rarakat	29c. LICENSE NUMBER: D21684	29d. DATE SIGNED (Month, Day, Year): ▶ 12/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. RARAKAT 310 W. 9th street Frederick MD 21701		
31. DATE FILED (Month, Day, Year): DEC 19 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37643

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIE MAE SMALLWOOD HENDERSON
2. DATE OF DEATH (Month, Day, Year): Dec. 25, 1989
3. TIME OF DEATH: 5:50 p. M
4. SOCIAL SECURITY NUMBER: 219-54-1001
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 91 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 9, 1898
8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Vindabona Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Braddock Heights
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1000 F Heather Ridge Dr., Apt. 214
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8 +)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife
16b. KIND OF BUSINESS/INDUSTRY: na
17. FATHER'S NAME (First, Middle, Last): John Weedon
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Robinson
19a. INFORMANT'S NAME (Type/Print): Clara Scott
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1000 F Heather Ridge Dr. Apt. 214, Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Sunnyside Church Cemetery
20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmon
22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral HOme, 1621 Opossumtown Pike, Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: L Kincland
29c. LICENSE NUMBER: P22037
29d. DATE SIGNED (Month, Day, Year): ▶ 12-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): L KINCAND 610 NINTH AVE, BRUNSWICK, MD
31. DATE FILED (Month, Day, Year): DEC 27 1989
32. REGISTRAR'S SIGNATURE: Lucia Davidson-Randall

DHMH-18 Rev 1/89

89 37644

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT Lee HARDING | HARDING
2. DATE OF DEATH (Month, Day, Year): 12/8/89
3. TIME OF DEATH: 1:15P M
4. SOCIAL SECURITY NUMBER: 218-01-8859
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 11, 1914
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7025 Summerfield Dr.
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 | College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Structural Planning Engineer
16b. KIND OF BUSINESS/INDUSTRY: U.S. Government
17. FATHER'S NAME (First, Middle, Last): unknown
18. MOTHER'S NAME (First, Middle, Maiden Surname): unknown
19a. INFORMANT'S NAME (Type/Print): Virginia D. Harding
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7025 Summerfield Dr., Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Neelsville Cemetery
20c. LOCATION — City or Town, State: Germantown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth
22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Renal carcinoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John A. Vitarello M.D.
29c. LICENSE NUMBER: 027544
29d. DATE SIGNED (Month, Day, Year): ▶ 12/9/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 310 W 9th ST Frederick, Md 21701
31. DATE FILED (Month, Day, Year): DEC 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DHMH-16 Rev 1/89

89 37645

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martha Eliza Hoy Martha Eliza Hoy			2. DATE OF DEATH: MONTH 11 DAY 30 YEAR 89	3. TIME OF DEATH: 0240 AM
4. SOCIAL SECURITY NUMBER: 213-18-9248	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 64 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-12-25	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick, Md.		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Monrovia	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 4540 Green Valley Road	10f. ZIP CODE: 21770		10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): House Keeping	16b. KIND OF BUSINESS/INDUSTRY: Comfort Inn	
17. FATHER'S NAME (First, Middle, Last): John Edgar Spriggs		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Frances Chase Spriggs	
19a. INFORMANT'S NAME (Type/Print): Walter Spriggs		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4532 Green Valley Rd., Monrovia, MD 21770	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Ebenezer Church Cemetery	20c. LOCATION — City or Town, State: Centerville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. TERMINAL METASTATIC CANCER OF THE PANCREAS	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: ☒ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Glenn R. Hamrick, M.D.	29c. LICENSE NUMBER: D-18191	29d. DATE SIGNED (Month, Day, Year) ▶ 11/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 187 Thomas Johnson Dr. Frederick, MD. 21701		
31. DATE FILED (Month, Day, Year): DEC 01 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 37646

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louyse Genevieve Hollar
2. DATE OF DEATH (Month, Day, Year): Dec. 21, 1989
3. TIME OF DEATH: 11 P. M
4. SOCIAL SECURITY NUMBER: 220-54-2505
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 30, 1912
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Brunswick
10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 707 E. B St.
10f. ZIP CODE: 21716
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker
16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): John W. Derflinger
18. MOTHER'S NAME (First, Middle, Maiden Surname): Grace R. Ault
19a. INFORMANT'S NAME (Type/Print): Donald W. Hollar
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Bedford Dr., Jefferson, Md. 21755
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union Cemetery
20c. LOCATION — City or Town, State: Lovettsville, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B. Thompson
22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Broncho-pneumonia	1 Week
DUE TO (OR AS A CONSEQUENCE OF): b.	Perforated gastric ulcer	2 Weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Senile Dementia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Bernard O. Tumas Jr.
29c. LICENSE NUMBER: D13409
29d. DATE SIGNED (Month, Day, Year): ▶ Dec. 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): DEC 29 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37647

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Francis Haky		2. DATE OF DEATH (Month, Day, Year): November 29 1989	3. TIME OF DEATH: 0545A M
4. SOCIAL SECURITY NUMBER: 174-18-9678	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): April 4, 1920
8. BIRTHPLACE (State or Foreign Country): Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1305 Taney Avenue	10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ ND IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC DRIDIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brick Layer	16b. KIND OF BUSINESS/INDUSTRY: Carneige Illinois Steel
17. FATHER'S NAME (First, Middle, Last): Joseph Haky		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Haky	
19a. INFORMANT'S NAME (Type/Print): Helen Heim Haky		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1305 Taney Avenue, Frederick, Md 21701	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brenda L. Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, DR COMPLICATIONS that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ONE cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. resp arrest		
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. extensive Transitional cell		
DUE TO (OR AS A CONSEQUENCE OF):		
c. Ca bladder		6 mo
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D14626	29d. DATE SIGNED (Month, Day, Year): ▶ 11/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 501 W Seventh St Frederick MD 21701

31. DATE FILED (Month, Day, Year): NOV 30 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37648

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Dorsey Hemp			2. DATE OF DEATH (Month, Day, Year): Dec. 18 1989	3. TIME OF DEATH: 2 43 p.M
4. SOCIAL SECURITY NUMBER: 214-10-2903	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): July 30, 1898	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Home for The Aged		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 115 Record Street		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10 years; College (1-4 or 5+): - - - - -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Lady		16b. KIND OF BUSINESS/INDUSTRY: Clothing Dept. Stores
17. FATHER'S NAME (First, Middle, Last): Lloyd Duvall Roelke		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen Rebecca Dorsey	
19a. INFORMANT'S NAME (Type/Print): Home For The Aged		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 Record St., Frederick, Md. 21701	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert W. Keeney M00652		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 E. Church St.,Frederick, Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Multiple myeloma	18 mos
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Nephrotic syndrome	18 mos.
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: LeRoy T Davis MD	29c. LICENSE NUMBER: D01902	29d. DATE SIGNED (Month, Day, Year): 12/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. LeRoy T. Davis, M.D. 801 Toll House Ave.,Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): DEC 20 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37649

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Oliver Hilton

2. DATE OF DEATH (Month, Day, Year): Dec. 4, 1989

3. TIME OF DEATH: 8:54 A.M.

4. SOCIAL SECURITY NUMBER: 219-12-8293

6. SEX: 1 [X] M 2 [ ] F

6. AGE (In yrs. last birthday): 68 YRS.

IF UNDER 1 YEAR: MONTHS / DAYS

IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 4/28/1921

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Olney

9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Woodbine

10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER: 7135 Annapolis Rock Road

10f. ZIP CODE: 21797

10g. CITIZEN OF WHAT COUNTRY?: American

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES: World War II

13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 [ ] YES 2 [X] NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5 +):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist

16b. KIND OF BUSINESS/INDUSTRY: Tool Making

17. FATHER'S NAME (First, Middle, Last): James F. Hilton

18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Mary Snyder

19a. INFORMANT'S NAME (Type/Print): Esther M. Hilton

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): =7135 Annapolis Rock Rd., Woodbine, Md 21797

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Tabor Cemetery

20c. LOCATION — City or Town, State: Etchison, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Williams

22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A., Funeral Home
Damascus, Maryland 20872

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrhythmia	5 min.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Atherosclerotic Cardiovascular Disease	7 yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Chronic respiratory failure, chronic renal compromise, diffuse vascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Jules R. Lodish MD

29c. LICENSE NUMBER: MD 31612

29d. DATE SIGNED (Month, Day, Year): ▶ 12/4/1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jules R. Lodish, M.D., 2901 Olney-Sandy Spring Rd., Olney, Md. 20832

31. DATE FILED (Month, Day, Year): DEC 06 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37650

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ruth T. Herrell — Ruth Taylor HERRELL	2. DATE OF DEATH (Month, Day, Year): Dec. 14, 1989	3. TIME OF DEATH: 2145 M	
4. SOCIAL SECURITY NUMBER: 220-16-0799	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3/22/1900
8. BIRTHPLACE (State or Foreign Country): Virginia XXXXXXXXXXXX			
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 429 Edgewood Drive	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook	16b. KIND OF BUSINESS/INDUSTRY: Restaurant	
17. FATHER'S NAME (First, Middle, Last): James Taylor	18. MOTHER'S NAME (First, Middle, Maiden Surname): Hester Newcome		
19a. INFORMANT'S NAME (Type/Print): Claude Herrell	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 429 Edgewood Drive, South, Hagerstown, Md. 21740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens	20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Gray M00255	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBRAL THROMBOSIS	4 DAYS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CEREBRAL ATHEROSCLEROSIS	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NONE	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D01040	29d. DATE SIGNED (Month, Day, Year): ▶ 12-15-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): BARRY M. COHEN, 339 E. ANTIETAM ST, HAGERSTOWN, MD, 21740		
31. DATE FILED (Month, Day, Year): DEC 18 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Kendall	

DHMH-18 Rev 1/89

6

89 37651

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Aline Joanna HETTICH / Aline J. Hettich		2. DATE OF DEATH — MONTH: 12 DAY: 27 YEAR: 89	3. TIME OF DEATH: 9:10 P M
4. SOCIAL SECURITY NUMBER: 212-74-8466	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 96 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 20, 1893
8. BIRTHPLACE (State or Foreign Country): Germany			
9a. FACILITY NAME (If not institution, give street and number): Colton Villa Nursing Home	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 33 Redwood Drive	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): – / College (1-4 or 5+): –	16a. OECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Albert Grams	18. MOTHER'S NAME (First, Middle, Maiden Surname): Karoline Wendt		
19a. INFORMANT'S NAME (Type/Print): Elizabeth W. Noll	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 33 Redwood Dr., Hagerstown, Md. 21740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery	20c. LOCATION — City or Town, State: Hagerstown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Scott Minnich	22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CEREBRO VASCULAR ACCIDENT	7 MONTHS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

DEHYDRATION
GANGRENOUS TOE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD	29c. LICENSE NUMBER: D01040	29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BARRY W. COHEN, 339 E. ANTIETAM ST, HAGERSTOWN, MD 21740

31. DATE FILED (Month, Day, Year): 12-DEC 29 '89	32. REGISTRAR'S SIGNATURE: Jackie Davidson-Mandell

DHMH-16 Rev 1/89

89 37652

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Linda Carol HAZZARD					2. DATE OF DEATH (Month, Day, Year): December 25, 1989	3. TIME OF DEATH: 1:00 P.M. M
4. SOCIAL SECURITY NUMBER: 222- 30- 9741	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 40 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 2, 1949	8. BIRTHPLACE (State or Foreign Country): Milford, Del.
9a. FACILITY NAME (If not institution, give street and number): 20409 Bent Willow Rd.			9b. CITY, TOWN OR LOCATION OF DEATH: Rohrersville		9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Rohrersville	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 20409 Bent Willow Rd.		10f. ZIP CODE: 21779	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Sales Clerk	16b. KIND OF BUSINESS/INDUSTRY: Craft Store
17. FATHER'S NAME (First, Middle, Last): Wilson Maclyn Cullum	18. MOTHER'S NAME (First, Middle, Maiden Surname): Alberta Mary Davidson	
19a. INFORMANT'S NAME (Type/Print): Francis Robert Hazzard, Jr.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 20409 Bent Willow Rd. Rohrersville, Md. 21779	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☒ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Conley's Chapel Cemetery	20c. LOCATION — City or Town, State: Lewes, Delaware
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John H. Bast, Jr.	22. NAME AND ADDRESS OF FACILITY: BAST FUNERAL HOME,	7606 Boonsboro Pike Boonsboro, Md. 21713

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma Liver — Metastatic	18 Mos.
DUE TO (OR AS A CONSEQUENCE OF):	b. (Primary lesion Undetermined)	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Edward W. Dittmar	D0 1062	▶ Dec 26, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Dittmar M.D. - 217 W. Washington St Hagerstown, Md 21740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 '89	Jackie Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37653

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 & 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn Matilda Hubbard				2. DATE OF DEATH (Month, Day, Year): 12-26-89	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 217-03-5985	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 74 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08-20-15	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 513 Old Denton Road			9b. CITY, TOWN OR LOCATION OF DEATH: Federalsburg		9c. COUNTY OF DEATH: Caroline
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 513 Old Denton Road		10f. ZIP CODE: 21632		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: N/A			
17. FATHER'S NAME (First, Middle, Last): Edward Dodd Holden		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie Boone Holden			
19a. INFORMANT'S NAME (Type/Print): Mr. Hervey Hubbard		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 513 Old Denton Rd., Federalsburg, MD 21632			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hillcrest Cemetery		20c. LOCATION — City or Town, State: Federalsburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Eskow		22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute myocardial infarction	acute
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease	yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Arteriosclerosis Generalized	yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes mellitus, severe

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Albert T. Dawkins Jr. M.

29c. LICENSE NUMBER: D7872 (Maryland)

29d. DATE SIGNED (Month, Day, Year): ▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALBERT T. DAWKINS JR 508 LOCUST AVENUE EASTON, MARYLAND 21601

31. DATE FILED (Month, Day, Year): JAN 8 '90

32. REGISTRAR'S SIGNATURE: Lisa Davidson-Randall

DHMH-16 Rev 1/89

89 37654

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dallas ELMER JEWELL
2. DATE OF DEATH (Month, Day, Year): Dec. 25, 1989
3. TIME OF DEATH: 7:00 P M
4. SOCIAL SECURITY NUMBER: 222 09 7172
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 67 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)
7. DATE OF BIRTH (Month, Day, Year): MARCH 5, 1922
8. BIRTHPLACE (State or Foreign Country): DELAWARE
9a. FACILITY NAME (If not institution, give street and number): Deer's Head Center
9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury
9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: DELAWARE
10b. COUNTY: SUSSEX
10c. CITY, TOWN OR LOCATION: SEAFORD
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: RD 4 BOX 436
10f. ZIP CODE: 19973
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 YRS; College (1-4 or 8 +):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): TRUCKER
16b. KIND OF BUSINESS/INDUSTRY: SOIL SERVICE, INC. SEAFORD, DEL.
17. FATHER'S NAME (First, Middle, Last): WILLIAM HENRY JEWELL
18. MOTHER'S NAME (First, Middle, Maiden Surname): OLA LAVENIA JOSEPH JEWELL
19a. INFORMANT'S NAME (Type/Print): MARGARET PASSWATERS JEWELL
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RD 4 BOX 436; SEAFORD, DELAWARE 19973
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BLADES CEMETERY
20c. LOCATION — City or Town, State: BLADES, DELAWARE
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Mary W. States
22. NAME AND ADDRESS OF FACILITY: FUNERAL HOME, INC. FRONT & KING STREETS SEAFORD, DELAWARE 19973

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Staphylococcus Septicemia (MRSA)	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Abscess and decubitus ulcer (R) Hip	
DUE TO (OR AS A CONSEQUENCE OF):		
	c. S/P Total (R) Hip replacement	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: History of Subarachnoid hemorrhage with secondary Hydroccephalus with SP Ventricular peritoneal shunt & pseudomonas meningitis H/O Mini strokes

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: M. Shrestha M D
29c. LICENSE NUMBER: D16278
29d. DATE SIGNED (Month, Day, Year): 12-25-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maheswari Shrestha, M.D.; P.O. Box 2018; Salisbury, Md. 21802
31. DATE FILED (Month, Day, Year): DEC 29 '89
32. REGISTRAR'S SIGNATURE: Zeta Davidson-Randall

DNMN-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37655

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. It must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Evelyn JUNE JONES					2. DATE OF DEATH: MONTH 12 DAY 22 YEAR 89	3. TIME OF DEATH: 11:15 AM
4. SOCIAL SECURITY NUMBER: 213-24-1403	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 6- 16- 1927	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO	
RESIDENCE OF DECEDENT						
10a. STATE: DELAWARE	10b. COUNTY: SUSSEX	10c. CITY, TOWN OR LOCATION: SEAFORD			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO	
10e. STREET AND NUMBER: MAIN STREET, INDIAN VILLAGE # 12		10f. ZIP CODE: 19973			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 YEARS; College (1-4 or 5 +): ---		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UPHOLSTER			16b. KIND OF BUSINESS/INDUSTRY: OWN SHOP	
17. FATHER'S NAME (First, Middle, Last): WEBSTER BYRAN METZ					18. MOTHER'S NAME (First, Middle, Maiden Surname): ELIZABETH --- COOK	
19a. INFORMANT'S NAME (Type/Print): MAURICE R. JONES, SR.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): INDIAN VILLAGE, SEAFORD, DELAWARE 19973				
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/23/89		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SALISBURY CREMATORY			20c. LOCATION — City or Town, State: SALISBURY, MD 21801	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ignatius J. DiNardo M.D.	D31546	▶ 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ignatius L. DiNardo M.D. P.O. Box 640 Princess Anne, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 '89	[signature]

DHMH-16 Rev 1/89

89 37656

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): No name submitted (Boy A) Jenkins			2. DATE OF DEATH (Month / Day / Year): 5 / 2 / 89	3. TIME OF DEATH: 1045 p M
4. SOCIAL SECURITY NUMBER: n/a	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): n/a YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. 25	7. DATE OF BIRTH (Month, Day, Year): 5/2/89	8. BIRTHPLACE (State or Foreign Country): Montgomery
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 507 North Horners Lane		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 XX Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+)	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	15b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Bernard Lane Jenkins, Jr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Beth Diane Weiss	
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shady Grove Adventist Hospital	20c. LOCATION — City or Town, State: Rockville
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: 9901 Medical Ctr. Dr. Rockville, MD 20850	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme prematurity

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D27899	29d. DATE SIGNED (Month, Day, Year): ▶ 1-3-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robert Buczek, 9901 Med. Ctr. Dr., Rockville, MD 20850		
31. DATE FILED (Month, Day, Year): 1-3 JAN 11 90	REGISTRAR'S SIGNATURE: Wanda Davis	

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LEE R. JOHNSON					2. DATE OF DEATH (Month, Day, Year): December 28, 1989		3. TIME OF DEATH: 4:33P M
4. SOCIAL SECURITY NUMBER: 578 18 2582	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 90 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-31-99		8. BIRTHPLACE (State or Foreign Country): W.V.
9a. FACILITY NAME (If not institution, give street and number): V.A. Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Perry Point		9c. COUNTY OF DEATH: Cecil		
RESIDENCE OF DECEDENT							
10a. STATE: Washington,DC	10b. COUNTY: District of Columbia		10c. CITY, TOWN OR LOCATION: Washington, D.C.		10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO		
10e. STREET AND NUMBER: 456 C Street, N.W.			10f. ZIP CODE: 20001		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.		
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: 10/4/18 - 12/13/18		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+): Unknown			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer		16b. KIND OF BUSINESS/INDUSTRY: Retired		
17. FATHER'S NAME (First, Middle, Last): Robert Johnson			18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Coleman				
19a. INFORMANT'S NAME (Type/Print): V.A.M.C. Medical Records			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Perry Point, Maryland 21902				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Quantico National Cemetery		20c. LOCATION — City or Town, State: Triangle, Virginia		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Lee A. Patterson, Sr.			22. NAME AND ADDRESS OF FACILITY: Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF): Arteriosclerotic heart disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined			1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
STANLEY I. PHIPPIPS, M.D.	D25622	▶ 1/2/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stanley I. Phillips M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 12 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should accompany the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Donald Henry Johnson			2. DATE OF DEATH: Month Dec, Day 25, Year 1989	3. TIME OF DEATH: 9:40 A M
4. SOCIAL SECURITY NUMBER: 205-38-7426	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 57 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12-13-1932	8. BIRTHPLACE (State or Foreign Country): PA
9a. FACILITY NAME (If not institution, give street and number): at home - 115 High Street		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 115 High Street		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U S

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Snider's Elevator, Inc. Williamson, PA	
17. FATHER'S NAME (First, Middle, Last): -		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret E. Johnson	
19a. INFORMANT'S NAME (Type/Print): Margaret E. Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 High Street, Hagerstown, MD 21740	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shank's Church Cemetery	20c. LOCATION — City or Town, State: Greencastle, PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert D May		22. NAME AND ADDRESS OF FACILITY: Minnich-Miller-May Funeral Home 112 E. Baltimore St., Greencastle, PA 17225	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Congestive Heart Failure	7 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Heart Disease	5 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W. Dittom MD	29c. LICENSE NUMBER: D01062	29d. DATE SIGNED (Month, Day, Year): ▶ Dec 26, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Dittom MD 217 W. Washington St Hagerstown, MD 21740

31. DATE FILED (Month, Day, Year): JAN 04 '90	32. REGISTRAR'S SIGNATURE: Gina Davidson-Kendall

DHMH-18 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 4:10 am

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ELLSWORTH M. KING — ELLSWORTH M. KING
2. DATE OF DEATH: MONTH 11 DAY 29 YEAR 89
3. TIME OF DEATH: 4:10 AM
4. SOCIAL SECURITY NUMBER: 217-14-7913
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 75 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 01-30-14
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Kensington Gardens Nursing Center
9b. CITY, TOWN OR LOCATION OF DEATH: Kensington MD.
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Gaithersburg
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 24005 Woodfield Road
10f. ZIP CODE: 20882
10g. CITIZEN OF WHAT COUNTRY?: American
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Carpenter
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Cramwell M. King
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ivy Blanche Broadhurst
19a. INFORMANT'S NAME (Type/Print): Eugene M. King
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3124 Plyers Mill Rd., Kensington, Md. 20895
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Wesley Grove Cemetery
20c. LOCATION — City or Town, State: Woodfield, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth
22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A., Funeral Home Damascus, Maryland 20872

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. GENERALIZED ARTERIOSCLEROSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. DIABETES MELLITUS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: D08544
29d. DATE SIGNED (Month, Day, Year): ▶ 11/29/89
29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John J. Merendino, M.D., 4701 Randolph Rd., Rockville, Md. 20852
31. DATE FILED (Month, Day, Year): DEC 04 1989
32. REGISTRAR'S SIGNATURE: Julia Davison-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37660

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BARBARA ANN Kimmel				2. DATE OF DEATH MONTH 11 DAY 30 YEAR 89	3. TIME OF DEATH 1245 M
4. SOCIAL SECURITY NUMBER: 212-38-7865	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 51 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)		7. DATE OF BIRTH (Month, Day, Year): 8/11/1938	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 4981 New Design Road		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home	
17. FATHER'S NAME (First, Middle, Last): John Edward Mulcahey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Susie Lee Day			
19a. INFORMANT'S NAME (Type/Print): William K. Kimmel		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 262 Frederick, Md. 21701			
20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens		20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Gray M00255		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiogenic shock

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated avente resulting in death) LAST

b. myocardial infarction

DUE TO (OR AS A CONSEQUENCE OF):

c. cardiac arrest at home 2° ventricular tachycardia

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John A. Vitarello M.D.	027544	▶ 11/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 310 W. 9th ST. Frederick, Md 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
11/30/8 DEC 01 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 37661

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Luther John KINNA			2. DATE OF DEATH: December 25, 1989	3. TIME OF DEATH: 5:25 A. M
4. SOCIAL SECURITY NUMBER: 219-07-8827	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 14, 1917	8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 238 West Fifth Street		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: World War II	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Labor	16b. KIND OF BUSINESS/INDUSTRY: Canning Factory	
17. FATHER'S NAME (First, Middle, Last): John Luther Kinna	18. MOTHER'S NAME (First, Middle, Maiden Surname): Ethel Olive Wiles		
19a. INFORMANT'S NAME (Type/Print): Mrs. June A. Kinna	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 238 West Fifth Street, Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allan H Ruby M00703	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home, 21701 106 East Church Street, Frederick, Md.,		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	minutes
	DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Cardiovascular Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF): Hypertension	year
	c.	
	DUE TO (OR AS A CONSEQUENCE OF): Diabetes	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Allen J Olson ATTENDING	29c. LICENSE NUMBER: D26516	29d. DATE SIGNED (Month, Day, Year): ▶ 12/25/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1475 TANEY AVE FRED MD 21701			
31. DATE FILED (Month, Day, Year): DEC 26 1989	32. REGISTRAR'S SIGNATURE: Julia Patterson		

DNMH-18 Rev 1/89

89 37662

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

R

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Margaret Estelle KOOGLE (Margaret Estelle Koogle)			2. DATE OF DEATH (Month / Day / Year): 12 / 16 / 89	3. TIME OF DEATH: 0620 AM
4. SOCIAL SECURITY NUMBER: 212-78-0828	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 80 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 30, 1909	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 225 East Fourth Street		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): James Pinkney Unglesbee		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Rebecca Stockman	
19a. INFORMANT'S NAME (Type/Print): Miss M. Patricia Koogle	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 225 East Fourth St., Frederick, MD. 21701		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lutheran Cemetery	20c. LOCATION — City or Town, State: Jefferson, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Lynn Robeson M00706	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Massive Cerebral Infarct	4 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Willis Riddick MD	29c. LICENSE NUMBER: D 12482	29d. DATE SIGNED (Month, Day, Year): ▶ 12/16/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Willis J. Riddick, MD., 516 Trail Avenue, Frederick, Maryland 21701

31. DATE FILED (Month, Day, Year): DEC 18 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondeau

DHMH-16 Rev 1/89

3

89 37663

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dulcie LaRue Keilholtz			2. DATE OF DEATH MONTH 12 DAY 14 YEAR 89	3. TIME OF DEATH 1200 M
4. SOCIAL SECURITY NUMBER: 220-34-1076	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year): 11/11/1908	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Emmitsburg	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 17252 Mountainview Road		10f. ZIP CODE: 21727	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cafeteria Supervisor	16b. KIND OF BUSINESS/INDUSTRY: High School
17. FATHER'S NAME (First, Middle, Last): William Edward Burdette		18. MOTHER'S NAME (First, Middle, Maiden Surname): Virginia Louise May	
19a. INFORMANT'S NAME (Type/Print): William Keilholtz, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 149 N. Carroll ST., Thurmont, Md. 21788	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Graceham Moravian Cemetery	20c. LOCATION — City or Town, State: Thurmont, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Md. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	5 hours
DUE TO (OR AS A CONSEQUENCE OF): b.	A S H D	1-2-4-5
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Acute cholecystitis & sepsis	3 days
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Timothy Shockley	29c. LICENSE NUMBER: D01711	29d. DATE SIGNED (Month, Day, Year) ▶ 12/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): DEC 15 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37664

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lenora Alice Crum Kling (Lenora Alice Kling)
2. DATE OF DEATH (Month, Day, Year): 12-12-89
3. TIME OF DEATH: 1:15 P M
4. SOCIAL SECURITY NUMBER: 220-34-1041
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9-1-1897
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Walkersville
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 8901 Crum Road
10f. ZIP CODE: 21793
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Farmer
17. FATHER'S NAME (First, Middle, Last): Solamon Crum
18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Bernetta Hahn Crum
19a. INFORMANT'S NAME (Type/Print): Charlotte K. Rupert
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8901 Crum Road, Walkersville, MD 21793
20a. METHDD DF DISPOSITIDN: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Hope
20c. LOCATION — City or Town, State: Woodsboro, Md
21. SIGNATURE DF FUNERAL SERVICE LICENSEE: ▶ Wanda L. Lemmer
22. NAME AND ADDRESS DF FACILITY: Stauffer Funeral Homes, PA, P.O. Box 1819, Frederick, Md 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, DF complications that caused the death. Do nDt anter the mode of dying, such as cardiac or respiratory arrest, shock, DF heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardio Pulmonary Arrest DUE TO (DR AS A CONSEQUENCE DF): — Approximate Interval Between Onset and Death: 24 Hours

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST:
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION DF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME DF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATIDN (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert L. Kaufman, MD
29c. LICENSE NUMBER: D-13971
29d. DATE SIGNED (Month, Day, Year): ▶ 12/12/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): DEC 14 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37665

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) MARTHA MARY KOCH / MARTHA MARY KOCH			2. DATE OF DEATH MONTH DAY YEAR: December 17 1989	3. TIME OF DEATH: 0025A M
4. SOCIAL SECURITY NUMBER: 171 07 2584	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 5, 1915	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial HOspital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 616 Lee Place		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Blueprint operator		16b. KIND OF BUSINESS/INDUSTRY: Parsons Engineering
17. FATHER'S NAME (First, Middle, Last): James Bertford Wiley		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Mary Weamer		
19a. INFORMANT'S NAME (Type/Print): Tim Wiley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6386 Overbrook Circle, Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet		20c. LOCATION — City or Town, State: Frederick, Md. 21701
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brenda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike, Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RENAL FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. CHRONIC PYELONEPHRITIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: posbl pneumonia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and menner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gary L. Smith Jr M.D.	29c. LICENSE NUMBER: D10587	29d. DATE SIGNED (Month, Day, Year) ▶ 12/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): DEC 19 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37666

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Marie Karamanos	Marie	NMN	KARAMANOS	2. DATE OF DEATH MONTH 12 DAY 22 YEAR 89	3. TIME OF DEATH 607 pm M		
4. SOCIAL SECURITY NUMBER 217 09 9689	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 16, 1902	8. BIRTHPLACE (State or Foreign Country) Yugoslavia		
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital	9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	9c. COUNTY OF DEATH Washington					
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO				
10e. STREET AND NUMBER 832 Armstrong Avenue	10f. ZIP CODE 21740	10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 8 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) hairdresser	16b. KIND OF BUSINESS/INDUSTRY beauty salon					
17. FATHER'S NAME (First, Middle, Last) Michael Rudman	18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Gudall						
19a. INFORMANT'S NAME (Type/Print) Michael Rudman	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3680 Oakleaf Rd., Pittsburgh, Pa. 15227						
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery	20c. LOCATION — City or Town, State Hagerstown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Scott Minnick	22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740						

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CVA

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. MI

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 5 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year) ▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carol Pattabiraj 336 Mill St. Hag MC

31. DATE FILED (Month, Day, Year) DEC 27 '89

32. REGISTRAR'S SIGNATURE Julia Davidson-Randall

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37667

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN W. KINNAHAN				2. DATE OF DEATH (Month, Day, Year): 12 28 89	3. TIME OF DEATH: 7:45 PM M
4. SOCIAL SECURITY NUMBER: 217-42-4501	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 4-6-1913	8. BIRTHPLACE (State or Foreign Country): WASHINGTON DC
9a. FACILITY NAME (If not institution, give street and number): HOLY CROSS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SILVER SPRING, MD.		9c. COUNTY OF DEATH: MONTGOMERY	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: MONTGOMERY	10c. CITY, TOWN OR LOCATION: BETHESDA	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO	
10e. STREET AND NUMBER: 6907 FAIRFAX ROAD		10f. ZIP CODE: 20814	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): LETTER CARRIER	16b. KIND OF BUSINESS/INDUSTRY: U.S. POST OFFICE		
17. FATHER'S NAME (First, Middle, Last):	18. MOTHER'S NAME (First, Middle, Maiden Surname): BENEVIENE			
19a. INFORMANT'S NAME (Type/Print): VIRGINIA LEE KINNAHAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): SAME AS #10			
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FT. LINCOLN CEMETERY	20c. LOCATION — City or Town, State: BRENTWOOD, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: James E. DeVol	22. NAME AND ADDRESS OF FACILITY: DeVOL FUNERAL HOME 2222 Wisc. Ave, N.W., WASH. D.C.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	
DUE TO (OR AS A CONSEQUENCE OF):	b. Pneumonitis	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. DUE TO (OR AS A CONSEQUENCE OF):	
DUE TO (OR AS A CONSEQUENCE OF):	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Chronic obstructive pulmonary disease; Hemiplegia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur S. Bunsen, M.D.	29c. LICENSE NUMBER: D 4418	29d. DATE SIGNED (Month, Day, Year): ▶ 12-28-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): JAN 4 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randell	

DHMH-16 Rev 1/89

6

89 37668

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH	DAY	YEAR	3. TIME OF DEATH
IRIS	Brown	LONG			12	27	1989	1615 M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-09-4238	1 ☐ M 2 ☒ F	95 YRS.					11-24-1894	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Riverwalk Manor Nursing Home	Salisbury	Wicomico

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD	Wicomico	Salisbury	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Riverside Homes	21801	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify: White	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Housewife	Own Home

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Sidney Tull Brown	Maria Jane Hobbs

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Pauline L. Robertson	328 Winterquarters Dr, Pocomoke City, MD 21851

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)	Parsons Cemetery	Salisbury, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ B. Keith Phippin	Bounds Funeral Home Salisbury, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease	15 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Carcinoma of Rectum

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Thomas C. Hill, M.D Medical Director	D 08008	▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
THomas C. Hill JR, 108 Pine Bluff Road Salisbury, Md 21801

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 28 '89	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37669

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GRACE McCULLOUGH LOWRY			2. DATE OF DEATH MONTH 12 - DAY 25 - YEAR 89	3. TIME OF DEATH 3:10 pM
4. SOCIAL SECURITY NUMBER: 215-09-2065	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9- 5- 1911	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): SALISBURY NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY	9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 408 PAMELA DR		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4 or 5 +): 2 YEARS		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOUSEWIFE	16b. KIND OF BUSINESS/INDUSTRY: HOME

17. FATHER'S NAME (First, Middle, Last): TALBOTT DENMEAD LEVERING		18. MOTHER'S NAME (First, Middle, Maiden Surname): GRACE -- McCULLOUGH	
19a. INFORMANT'S NAME (Type/Print): PAUL I LOWRY		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 408 PAMELA DR, SALISBURY, MD 21801	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARSONS CEMETERY	20c. LOCATION — City or Town, State: SALISBURY, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John T. Holloway		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute Myocardial Infarction	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary artery disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D29105	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37670

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month/Day/Year)	3. TIME OF DEATH
EDWARD	HOUCK	LEECH	12/24/89	5:00 a M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
207-14-9793	1 ■ M 2 ☐ F	63 YRS.			3- 1- 1926	MARYLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
DEER'S HEAD CENTER	SALISBURY	WICOMICO

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	WICOMICO	SALISBURY	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
721 EDGAR DRIVE	21801	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☒ YES 2 ☐ NO — MARINE WWII	1 ☐ YES 2 ☒ NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
UNK	UNK	ACCOUNTANT	UTILITIES

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
MAURICE EDWARD LEECH	ELIZABETH IRENE HOUCK

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JEAN WEBB LEECH	721 EDGAR DRIVE, SALISBURY, MD 21801

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	SALISBURY CREMATORY	SALISBURY, MD 21801

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ John M. Holloway	HOLLWOAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PULMMONARY METASTASIS DUE TO (OR AS A CONSEQUENCE OF):	
	c. CANCER OF LIVER DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

BRAIN METASTASIS.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Constante J Tan M.D.	MD.16725	▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
DR. CONSTANTE J. TAN M.D.	SALISBURY, MD. 21801

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 '89	Lidia Davidson-Fletcher

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37671

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Catherine Elizabeth Linthicum

2. DATE OF DEATH (Month, Day, Year): Dec. 22 1989

3. TIME OF DEATH: 12:17 PM

4. SOCIAL SECURITY NUMBER: 217-10-0729

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 81 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN.

7. DATE OF BIRTH (Month, Day, Year): Apr. 19, 1908

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Frederick

9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Beallsville

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 19541 Beallsville Road

10f. ZIP CODE: 20839

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 11 years
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretarial

16b. KIND OF BUSINESS/INDUSTRY: Lime Co.

17. FATHER'S NAME (First, Middle, Last): William T. Painter

18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie O. Poole

19a. INFORMANT'S NAME (Type/Print): Mrs. Bettie M. Nestor

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 19541 Beallsville Rd., Beallsville, Md. 20839

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery

20c. LOCATION — City or Town, State: Frederick, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert W. Keeney M00698

22. NAME AND ADDRESS OF FACILITY: Keeney & Basford Funeral Home 106 East Church St., Fred. Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Uremia complicated w/ pneumonia — 1-2 hrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Lymphocytic Leukemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

26d. DESCRIBE HOW INJURY OCCURED

26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R. Robert S. Hughes, MD

29c. LICENSE NUMBER: DO 5111

29d. DATE SIGNED (Month, Day, Year): ▶ 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Robert S. Hughes, M.D. 700 Montclaire Ave., Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): DEC 26 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37672

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Matthew L. Lindsey		2. DATE OF DEATH (Month, Day, Year): 12 24 89	3. TIME OF DEATH: 10:30 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 30 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 8/7/59
8. BIRTHPLACE (State or Foreign Country): Indiana			
9a. FACILITY NAME (If not institution, give street and number): North Arundel Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Glen Burnie	9c. COUNTY OF DEATH: Anne Arundel Co.	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Anne Arundel	10c. CITY, TOWN OR LOCATION: Severna Park	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 600 Whittier Parkway	10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY?: U.S.	

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Restaurant	
17. FATHER'S NAME (First, Middle, Last): James Lindsey	18. MOTHER'S NAME (First, Middle, Maiden Surname): Jeanette Weedman		
19a. INFORMANT'S NAME (Type/Print): Jeanette McClellan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1771 Duggin Switch Rd., Vine Grove, KY 40175		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Claggett Cemetery	20c. LOCATION — City or Town, State: Leitchfield, KY	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael P. Marzullo	22. NAME AND ADDRESS OF FACILITY: Marzullo Funeral Service 3981 Carrollton Rd., Upperco, MD 21155		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple Injurires	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12/24/89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Subject Pedestrian struck by auto
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): roadway			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. #2 at Severna Park, Md.

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mario F. Golle Jr. M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D. 111 Penn St. Balto., Md. 21201		
31. DATE FILED (Month, Day, Year): JAN 10 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE 89

89 37673

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
CLAUDE HARRY	LECOMPTE		DECEMBER 27, 1989	1310 M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
214-18-4466	X 1 M 2 F	69 YRS.			4-30-1920	Md.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
PENINSULA GENERAL HOSPITAL	SALISBURY, MARYLAND	WICOMICO

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?	10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Md.	Wicomico	Delmar	X 1 YES 2 NO	504 E. East St.	21875	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? / IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 Never Married 2 X Married 3 Widowed 4 Divorced	X 1 YES 2 NO — WW II	1 YES 2 X NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
8		Supervisor	DuPont Co. Seaford, De.

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Mace LeCompte	Virgie Morris LeCompte

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Geraldine M. LeCompte	504 E. East St. Delmar, Md. 21875

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	St. Stephens Cemetery	Delmar, De.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
William M. Short	Short Funeral Home P.O. Box 204 Delmar, De.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory srreat, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Lung Disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 YES 2 NO	1 YES 2 NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 YES 2 X NO	HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA	OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined		M	1 YES 2 NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Benito S. Chan MD	0-20050	12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
BENITO S. CHAN 347-D Riverside Dr. Salisbury, MD 21801

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 4 '90	[redacted]

10

OHMH-16 Rev 1/89

89 37674

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RELEASED BY

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Marie H. Leyendecker			2. DATE OF DEATH (Month, Day, Year): 12 / 31 / 1989	3. TIME OF DEATH: 5:40 P M
4. SOCIAL SECURITY NUMBER: 578 52 1898	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 62 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/12/27	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): Suburban Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery		
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 11235 Oak Leaf Drive	10f. ZIP CODE: 20901	10g. CITIZEN OF WHAT COUNTRY?: USA		
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 1/12; College (1-4 or 5+): 4 Years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Geico Insurance	16b. KIND OF BUSINESS/INDUSTRY: Insurance-Auditor		
17. FATHER'S NAME (First, Middle, Last): Joseph Leyendecker	18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Klein			
19a. INFORMANT'S NAME (Type/Print): Irwin Mahan	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11235 Oak Leaf Drive Silver Spring, Md. 20901			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	20c. LOCATION — City or Town, State: S.S.Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 New Hamp.Ave.S.S.Md.			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Coronary Heart Disease	years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Coronary Artery Atherosclerosis	years
c. DUE TO (OR AS A CONSEQUENCE OF):	Hypertension	years
d.	Renal Artery Atherosclerosis	years

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Acute Left Ventricular Failure
Chronic Congestive Heart Failure

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Harris H. Konker MD	29c. LICENSE NUMBER: D06017	29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): HARRIS H. KONKER, M.D.	10401 OLD GEORGETOWN ROAD BETHESDA, MARYLAND 20814	
31. DATE FILED (Month, Day, Year): JAN 4 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37675

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JOHN RUSSELL Morcom				2. DATE OF DEATH (Month, Day, Year): December 27, 1989	3. TIME OF DEATH: 0305 PM
4. SOCIAL SECURITY NUMBER: 220-10-8213	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11- 3- 1912	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 23 CEDARHURST VILLAGE		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): HIGHSCHOOL; College (1-4 or 5+): --	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MAINTANCE	16b. KIND OF BUSINESS/INDUSTRY: REAL ESTATE	
17. FATNER'S NAME (First, Middle, Last): JOHN THOMAS MORCOM		18. MOTNER'S NAME (First, Middle, Maiden Surname): JOSEPHA --- STEVENS	
19a. INFORMANT'S NAME (Type/Print): ESTHER HOLLOWAY MORCOM		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 23 CEDARHURST VILLAGE, SALISBURY, MD 21801	
20a. METNOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PARSONS CRMETERY	20c. LOCATION — City or Town, State: SALISBURY, MD 21801
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: W. R. Holloway Jr		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL H OME, PA 501 SNOW HILL RD, SALISBURY, MD 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cerebrovascular accident	10 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): b.	Generalized arteriosclerosis	yrs
DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Alzheimers

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John G Bulkeley M.D	29c. LICENSE NUMBER: 703599	29d. DATE SIGNED (Month, Day, Year): 12-27-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John T Bulkeley - 108 Pine Bluff Rd. Salisbury, Md		
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson Register	

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DHMH-18 Rev 1/89

89 37676

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS G. MUENCH				2. DATE OF DEATH (Month, Day, Year): DECEMBER 23, 1989	3. TIME OF DEATH: 6:45p.m. M
4. SOCIAL SECURITY NUMBER: 197-22-1897	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): MARCH 7, 1929	8. BIRTHPLACE (State or Foreign Country): EMMITSBURG, MD.
9a. FACILITY NAME (If not institution, give street and number): WASHIN GTON COUNTY HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN, MD.		9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: FREDERICK	10c. CITY, TOWN OR LOCATION: EMMITSBURG	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 16430 OLD EMMITSBURG RD.		10f. ZIP CODE: 21727	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE	16b. KIND OF BUSINESS/INDUSTRY: NONE	
17. FATHER'S NAME (First, Middle, Last): WALTER G. MUENCH		18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSE B. COOL	
19a. INFORMANT'S NAME (Type/Print): MARY LOU HOPKINS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1034 OLD DRIVE, WESTMINSTER, MD. 21157	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW ST. JOSEPH'S	20c. LOCATION — City or Town, State: EMMITSBURG, MD. 21727
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John M Skiles		22. NAME AND ADDRESS OF FACILITY: SKILES FUNERAL HOME 210 W. MAIN ST., EMMITSBURG, MD. 21727	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Neuromuscular Dystrophy

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D21457	29d. DATE SIGNED (Month, Day, Year) ▶ 12/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDUL WAHEED, MD - 10-10 OAK HILL AVE. HAGERSTOWN, MD

31. DATE FILED (Month, Day, Year): DEC 26 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37677

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH NAOMI MAY					2. DATE OF DEATH (Month, Day, Year): December 24, 1989		3. TIME OF DEATH: 6:30 a M
4. SOCIAL SECURITY NUMBER: 213-74-6719	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 8, 1905		8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Center					9b. CITY, TOWN OR LOCATION OF DEATH: Frederick,		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Frederick				10c. CITY, TOWN OR LOCATION: Thurmont		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 7511 Kelly Store Road					10f. ZIP CODE: 21788		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd Grade; College (1-4 or 5+):					16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Andrew Moore					18. MOTHER'S NAME (First, Middle, Maiden Surname): Marian Gosnell		
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy Smith					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6011 Quartet Lane Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Taylorsville Un. Meth Cemetery		20c. LOCATION — City or Town, State: Taylorsville, Md. Carroll Co.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey					22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 East Main St. Thurmont, Md. 21788		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PNEUMONIA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ALZHEIMERS DISEASE

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
George I. Smith M.D.	D10587	Dec. 24, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George I. Smith, Jr. M.D. 300 West 9th Street Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 [illegible] be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37678

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY CAROLINE MIDDAUGH (MARY CAROLINE MIDDAUGH)		2. DATE OF DEATH: MONTH 12 DAY 24 YEAR 89 (12 24 89)	3. TIME OF DEATH: 12:33 P.M. (12:33 P M)
4. SOCIAL SECURITY NUMBER: 534-03-8855	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 78 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year): March 22,1911
8. BIRTHPLACE (State or Foreign Country): WASHINGTON			
9a. FACILITY NAME (If not institution, give street and number): FREDERICK MEMORIAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: FREDERICK	9c. COUNTY OF DEATH: FREDERICK	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: CARROLL	10c. CITY, TOWN OR LOCATION: MOUNT AIRY	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 5 HOOD STREET	10f. ZIP CODE: 21771	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): CREDIT REPORTER	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): ROBERT INGERSOL NEU	18. MOTHER'S NAME (First, Middle, Maiden Surname): MARGARET CARTY		
19a. INFORMANT'S NAME (Type/Print): MRS. MARY FORD	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13603 JACOB'S ROAD, MOUNT AIRY, MARYLAND 21771		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SMITHSBURG CREMATORY	20c. LOCATION — City or Town, State: SMITHSBURG, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey III	22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET STREET, FREDERICK, MD.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiorespiratory Arrest — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiac Dysrhythmia — DUE TO (OR AS A CONSEQUENCE OF):	
	c. Atherosclerotic Cardiovascular — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur S. Moulon, M.D.	29c. LICENSE NUMBER: D-18191	29d. DATE SIGNED (Month, Day, Year): ▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 187 Thomas Johnson Dr. Frederick, MD. 21701

31. DATE FILED (Month, Day, Year): DEC 26 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37679

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) PAUL ALLEN MULLER (MULLET)			2. DATE OF DEATH MONTH 12 DAY 22 YEAR 89	3. TIME OF DEATH 10:30 a.m.
4. SOCIAL SECURITY NUMBER 067-09-7428	5. SEX 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday) 71 YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year) 4/18/1918	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
9a. FACILITY NAME (If not institution, give street and number) 6610 Charles DRive		9b. CITY, TOWN OR LOCATION OF DEATH Mt. Airy		9c. COUNTY OF DEATH Frederick
RESIDENCE OF DECEDENT				
10a. STATE MD.	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION MT. AIRY		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 6610 Charles Drive		10f. ZIP CODE 21771		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 12 College (1-4 or 5+): 4+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Washington Suburban Commission	
17. FATHER'S NAME (First, Middle, Last) Sam Muller		18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances ?		
19a. INFORMANT'S NAME (Type/Print) Virginia Muller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6610 Charles Dr., Mt. Airy, Md. 21771		
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory	20c. LOCATION — City or Town, State Smithsburg, Wash. Co. Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ J. Douglas Stauffer		22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic leiomyosarcoma of stomach	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Philip Schwartz MD	MD 19 0 24398	▶ 12-22-89 1:15 PM

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Philip Schwartz MD 15225 Shady Grove Rd #206 Rockville, MD 20850

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 1989	Julia Davidson-Randell

DHMH-16 Rev 1/89

89 37680

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MIRIAM VIRGINIA MOCK			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH: 0829 M
4. SOCIAL SECURITY NUMBER: 214-14-6078	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sep. 17, 1918	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1401 Pinewood Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1401 Pinewood Drive		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Coil Winder	16b. KIND OF BUSINESS/INDUSTRY: Airpax Manufacturing		
17. FATHER'S NAME (First, Middle, Last): Murray Cleveland Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Daisy M. Engle		
19a. INFORMANT'S NAME (Type/Print): Charles W. Mock	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1401 Pinewood Drive, Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▸ Richard E. Deal M00255	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert R R Roberts MD

29c. LICENSE NUMBER: D09867

29d. DATE SIGNED (Month, Day, Year): ▸ 10/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): R R R ROBERTS MD 15 W 7th ST Frederick Md 21701-4599

31. DATE FILED (Month, Day, Year): DEC 29 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

39 3760

Richard E. Hurd

89 37681

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY ELLEN MOCK (Mary Ellen Mock)
2. DATE OF DEATH (Month / Day / Year): 11 / 19 / 1989
3. TIME OF DEATH: 18:32 M
4. SOCIAL SECURITY NUMBER: 214-32-4270
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 79 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 04/04/10
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 166 B+O Ave
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: None
17. FATHER'S NAME (First, Middle, Last): Bedford Fisher
18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosie McCutcheon
19a. INFORMANT'S NAME (Type/Print): James M. Mock
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 241 East 6th Street Frederick, Maryland 21701
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul's Cemetery
20c. LOCATION — City or Town, State: Point Of Rocks, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey
22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market Street Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. DO NOT enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	[illegible]	
DUE TO (OR AS A CONSEQUENCE OF): b.	[illegible]	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.		
DUE TO (OR AS A CONSEQUENCE OF): d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: AND [illegible]

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]
29c. LICENSE NUMBER: D 21648
29d. DATE SIGNED (Month, Day, Year): ▶ 11/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): K. BARAKAT 310 W 9th Street Frederick MD 21701
31. DATE FILED (Month, Day, Year): NOV 21 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37682

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) George Ross MOBERLY / Moberly / George Ross Moberly			2. DATE OF DEATH (Month, Day, Year) December 3 1989	3. TIME OF DEATH 0445A M
4. SOCIAL SECURITY NUMBER 220-18-3198	5. SEX 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) April 18, 1926
8. BIRTHPLACE (State or Foreign Country) Maryland				

9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH Frederick	9c. COUNTY OF DEATH Frederick

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER 7116 Autumn Leaf Lane	10f. ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	

11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES 1-25-1946/5-21-1947	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor	16b. KIND OF BUSINESS/INDUSTRY Telephone Company	
17. FATHER'S NAME (First, Middle, Last) Charles Robert Moberly Jr	18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Viola Wisner		
19a. INFORMANT'S NAME (Type/Print) Mrs. Marian Moberly	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7116 Autumn Leaf Lane, Frederick, Maryland 21701		
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery	20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Keith Lynn Robertson M00706	22. NAME AND ADDRESS OF FACILITY Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. LIVER FAILURE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. POST NECROTIC CIRRHOSIS	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. HEPATOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. CHRONIC LYMPHOCYTIC LEUKEMIA	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gerald Winnan MD	D25151	▶ 12/3/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Gerald Winnan, MD 310 West Ninth Street, Frederick, Maryland 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 04 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 37683

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WALTER DOWNEY MAIN			2. DATE OF DEATH (Month, Day, Year): 12 14 89	3. TIME OF DEATH: 12 Noon
4. SOCIAL SECURITY NUMBER: 219-54-0819	5. SEX: 1 [X] M 2 [ ] F	8. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 31, 1898	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Pleasant View Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Mount Airy		9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Carroll	10c. CITY, TOWN OR LOCATION: Mount Airy	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 4101 Baltimore National Pike		10f. ZIP CODE: 21771	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer	16b. KIND OF BUSINESS/INDUSTRY: Agriculture	
17. FATHER'S NAME (First, Middle, Last): William I. Main		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie Grabill	
19a. INFORMANT'S NAME (Type/Print): Miss Margaret Ann Fritz	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 201 Cross Street, Mount Airy, Maryland 21771		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Lynn Robertson M00706	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	0 days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Bronchitis	yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Subacute Combined Systems Disease	over 10 yrs
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ASHD, CHF, Atrial fibrillation, neuropathy myelitis. Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): *	28b. TIME OF INJURY: M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Melvin J. Kordon MD	29c. LICENSE NUMBER: D06588	29d. DATE SIGNED (Month, Day, Year): 12/14/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mel. Kordon MD 2000 Century Plaza Columbia MD 21044			
31. DATE FILED (Month, Day, Year): DEC 18 1989	32. REGISTRAR'S SIGNATURE: Julia Tarleton-Randall		

DHMH-18 Rev 1/89

89 37684

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): HARRY Thomas Miller					2. DATE OF DEATH: MONTH 12 DAY 25 YEAR 89		3. TIME OF DEATH: 0641 M
4. SOCIAL SECURITY NUMBER: 214-16-1403	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept. 9, 1922		8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick			9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT							
10a. STATE: Md.	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Middletown			10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO	
10e. STREET AND NUMBER: 7810 Ifert Dr.			10f. ZIP CODE: 21769			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: W. W. II		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): teacher			16b. KIND OF BUSINESS/INDUSTRY: public schools	
17. FATHER'S NAME (First, Middle, Last): John G. Miller			18. MOTHER'S NAME (First, Middle, Maiden Surname): Goldie Wiles				
19a. INFORMANT'S NAME (Type/Print): Ruth Anne Miller			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): POB 83, Middletown, Md. 21769				
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lutheran Cemetery			20c. LOCATION — City or Town, State: Middletown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B Thompson			22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert R R Roberts MD	D09867	▶ 12/25/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): RR ROBERTS MD 15 W 7th St Frederick Md 21701-4599

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 29 1989	Julia Davidson-Randall

DNMN-16 Rev 1/89

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89 37685

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CONGETTA J. MIRANDA						2. DATE OF DEATH (Month, Day, Year): December 12, 1989	3. TIME OF DEATH: 0900 M
4. SOCIAL SECURITY NUMBER: 182-14-6366	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): Dec. 8, 1919	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 5511 Corral Lane			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick			9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Frederick Hillside Estates			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 5511 Corral Lane			10f. ZIP CODE: 21701			10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker			16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Michael Sandullo			18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Giordano				
19a. INFORMANT'S NAME (Type/Print): Ralph Miranda			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5511 Corral Lane Frederick, Maryland 21701				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Penn Lincoln Memorial Park			20c. LOCATION — City or Town, State: N. Huntingdon, Penn.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr			22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hepatic Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Amyloidosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: renal failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: A. Austin Pearre Jr.	29c. LICENSE NUMBER: D09689	29d. DATE SIGNED (Month, Day, Year): December 12,1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): A. Austin Pearre, Jr. M.D. 300 West 9th Street Frederick, Md. 21701		
31. DATE FILED (Month, Day, Year): DEC 12 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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89 37686

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Viola Main
2. DATE OF DEATH — MONTH: 12 DAY: 16 YEAR: 1989
3. TIME OF DEATH: 1830 PM
4. SOCIAL SECURITY NUMBER: 220-16-3092
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 65 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 27, 1924
8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Middletown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 8906 Hawbottom Rd.
10f. ZIP CODE: 21769
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES: X
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: X
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): homemaker
16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Gordon S. Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Jemima Rippeon
19a. INFORMANT'S NAME (Type/Print): John A. Main
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8906 Hawbottom Rd., Middletown, Md. 21769
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lutheran Cemetery
20c. LOCATION — City or Town, State: Middletown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B. Thompson
22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home, 31 E. Main St., Middletown, Md. 21769

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac ischemia	2d
DUE TO (OR AS A CONSEQUENCE OF): b.	pneumonia	2d
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	severe peripheral vascular disease	2 yrs.
d.	status post cerebrovascular accident	1 yr.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: syndrome of inappropriate antidiuretic hormones

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: S Hultzel Smith MD
29c. LICENSE NUMBER: 36701
29d. DATE SIGNED (Month, Day, Year): ▶ 12-16-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sara Hultsch-Smith M.D., 915 Tollhouse Rd. Suite 203 Frederick Md
31. DATE FILED (Month, Day, Year): DEC 20 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37687

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~Thomas~~ Thomas H. Mowen		2. DATE OF DEATH (Month / Day / Year): 12 / 30 / 89	3. TIME OF DEATH: 4:16 PM
4. SOCIAL SECURITY NUMBER: 220-18-0069	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 11, 1916	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Colton Villa Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown	9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 7 East Washington Street		10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Assembly Worker	16b. KIND OF BUSINESS/INDUSTRY: Mfg. Vending Machines	
17. FATHER'S NAME (First, Middle, Last): Samuel Avey Mowen		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mahala Susan Shives	
19a. INFORMANT'S NAME (Type/Print): Clara V. Squibb	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 25 N. Potomac St., Waynesboro, Pa. 17268		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rest Haven Cemetery	20c. LOCATION — City or Town, State: Hagerstown, Wash., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Neal Brady	22. NAME AND ADDRESS OF FACILITY: Andrew K. Coffman Funeral Home, Inc. 40 E. Antietam St., Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Ischemic Heart Disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Atrial Fibrillation
Chronic obstructive pulmonary Disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D2457	29d. DATE SIGNED (Month, Day, Year): ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ABDUL WAHEED MD. 1610 Oak Hill Ave. Hagerstown MD		
31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-16 Rev 1/89

89 37688

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Joseph MURPHY — John Joseph Murphy
2. DATE OF DEATH: MONTH Dec DAY 28 YEAR 1989
3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 173-16-2355
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 9, 1921
8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): 112 Meadowbrook Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Pennsylvania
10b. COUNTY: Allegheny
10c. CITY, TOWN OR LOCATION: McKeesport
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1501 Freemont Street
10f. ZIP CODE: 15132
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: W. W. II
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): supervisor-Accountant
16b. KIND OF BUSINESS/INDUSTRY: Westinghouse
17. FATNER'S NAME (First, Middle, Last): Charles Murphy
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Marie Melia
19a. INFORMANT'S NAME (Type/Print): Kevin Murphy
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 112 Meadowbrook Dr., Hagerstown, Md. 21740
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Penn Cremation Services
20c. LOCATION — City or Town, State: Pittsburgh, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert B. Rankin
22. NAME AND ADDRESS OF FACILITY: MINNICH FUNERAL HOME, 415 E. Wilson Blvd., Hagerstown, Md. 21740

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypertensive Cardio Vascular Disease	years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ ~~NO~~
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ ~~YES~~ 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ ~~Residence~~ 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ ~~Natural~~ 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W. Ditto III, M7
29c. LICENSE NUMBER: D0 1062
29d. DATE SIGNED (Month, Day, Year): ▶ Dec 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Ditto III MD 217 W. Washington St Hagerstown, Md 21740
31. DATE FILED (Month, Day, Year): DEC 29 '89
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

ONMN-18 Rev 1/89

89 37689

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Louis Lindo Nangeroni DVM
2. DATE OF DEATH (Month, Day, Year): 12 12 1989
3. TIME OF DEATH: 5:45 AM
4. SOCIAL SECURITY NUMBER: 157-07-4206
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): 71 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 9/13/18
8. BIRTHPLACE (State or Foreign Country): New Jersey
9a. FACILITY NAME (If not institution, give street and number): 1792 Harvest Drive
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 1792 Harvest Drive
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: 4/29/42 - 2/2/47
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 8 yrs
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DVM
16b. KIND OF BUSINESS/INDUSTRY: Veternarian
17. FATHER'S NAME (First, Middle, Last): Alfred Nangeroni
18. MOTHER'S NAME (First, Middle, Maiden Surname): Theresa Rippo
19a. INFORMANT'S NAME (Type/Print): Carrie Little Nangeroni
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1792 Harvest Drive Frederick, MD 21701
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematorium
20c. LOCATION — City or Town, State: Smithsburg, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr
22. NAME AND ADDRESS OF FACILITY: Robert E. Dailey & Son Funeral Homes PA 1201 N. Market St. Frederick, MD 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the ~~disease~~, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN DEATH
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CARDIAC DYSRHYTHMIA
DUE TO (OR AS A CONSEQUENCE OF):
c. HYPERTENSIVE ASCVD
DUE TO (OR AS A CONSEQUENCE OF):
d. END STAGE RENAL DISEASE

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
RIGHT LOWER LOBE PNEUMONIA
RIGHT PLEURAL EFFUSION

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER: D13713
29d. DATE SIGNED (Month, Day, Year): 12-12-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OTTO ROZA M.D. 1114 OAKHILL AV. HAGERSTOWN MD.
31. DATE FILED (Month, Day, Year): DEC 13 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37690

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FRANK PERRY, JR.			2. DATE OF DEATH: MONTH 12 DAY 23 YEAR 89	3. TIME OF DEATH: 2140 M
4. SOCIAL SECURITY NUMBER: 254-44-1601	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/19/29	8. BIRTHPLACE (State or Foreign Country): Georgia
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Salisbury		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 627 Decatur Avenue		10f. ZIP CODE: 21801		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Afro-American
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd Grade; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister		16b. KIND OF BUSINESS/INDUSTRY: Church of God
17. FATHER'S NAME (First, Middle, Last): FRANK PERRY, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY TILLER		
19a. INFORMANT'S NAME (Type/Print): Mrs. Chappell Perry		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 627 Decatur Avenue, Salisbury, MD 21801		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Green Acres Memorial Park		20c. LOCATION — City or Town, State: Salisbury, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Loretta B. Jolley		22. NAME AND ADDRESS OF FACILITY: Jolley Memorial Chapel, Rt. #2, Box 920,, Jersey Road, Salis., MD 21801		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pancreatic carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: none

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NONE; 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Rodney A. Wenrich, M.D.	29c. LICENSE NUMBER: D 15384	29d. DATE SIGNED (Month, Day, Year): ▶ 12/23/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RODNEY A. WENRICH 100 POWER ST. SALISBURY Md. 21801

31. DATE FILED (Month, Day, Year): DEC 26 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Tomlinson

+5

DNMN-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be ... the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARY (Mary Frances Proctor) PROCTOR			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH: 7:25 PM
4. SOCIAL SECURITY NUMBER: 214-58-1968	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 87 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 04-03-02	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CLINTON	9c. COUNTY OF DEATH: PRINCE GEORGES	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Capitol Heights	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 4311 Will Street		10f. ZIP CODE: 20743	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Carroll W. Thompson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Frances Thompson	
19a. INFORMANT'S NAME (Type/Print): Geraldine V. Curtis	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4311 Will St, Capitol Hgts. Md. 20743		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resurrection Cemetery	20c. LOCATION — City or Town, State: Clinton, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Martell Adams	22. NAME AND ADDRESS OF FACILITY: Adams Funeral Home, Aquasco, Md. 20608		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebro Vascular Accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NO - Asthma - Arthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R Mogan MD	29c. LICENSE NUMBER: 12564	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): REZA MOSTAAN 4235 26th Ave Md 20748		
31. DATE FILED (Month, Day, Year): JAN 16 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

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89 37692

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be removed and retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
JAMES	ISSAC	PROCTOR	DEC. 24, 1989	12: 55AM

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-44-1859	1 ☒ M 2 ☐ F	55 YRS.			07-05-'34	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
PHYSICIANS MEMORIAL HOSPITAL	LA PLATA MD.	CHARLES

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Charles	Malcolm	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Route 1 Box 287	20613	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
10th	n/a		PEPCO

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Raymond A. Proctor	Pearl Thompson

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mable Briscoe	Route 1 Box 287 Brandywine Md. 20613

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	St. Peter's Catholic Church	Waldorf, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Martell Adams	Adams Funeral Home Aquasco Md. 20608

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cirrhosis of liver with portal hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. GI bleeding from esophageal varices	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Severe coagulopathy - advanced cirrhosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Chronic obstructive pulmonary disease	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
I. Garcia, MD.	DO2548	▶ 12-24-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
DR. IGNACIO GARCIA 705 WICOMICO AVE. LA PLATA MD, 20646

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 16 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37693

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTY IRENE POTTER			2. DATE OF DEATH (Month, Day, Year): Dec. 26, 1989	3. TIME OF DEATH: 3:00 p.m.
4. SOCIAL SECURITY NUMBER: 218-24-9963	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 60 YRS. (If under 1 year: Months; Days. If under 24 hrs.: Hours; Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 11, 1929	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Frederick Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 426 Pinoak Place		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: white

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): -	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: n/a	
17. FATHER'S NAME (First, Middle, Last): George Washington Tregoning		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Mae Mercer	
19a. INFORMANT'S NAME (Type/Print): Paula Cleaver		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 426 Pinoak Place, Frederick, Md. 21701	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Central	20c. LOCATION — City or Town, State: Libertytown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, MD. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypovolemic shock	3 hrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Infection & anemia.	
	c. DUE TO (OR AS A CONSEQUENCE OF): Carcinomatosis.	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Thoracic Thoracic disease, Peptic ulcer disease, Colon, Hypertension, T/C/A, Senility

	24a. WAS AN AUTOPSY PERFORMED? 1 ☑ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA. OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 20408	29d. DATE SIGNED (Month, Day, Year): ▶ 26 Dec 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Glen F. Brooks, M.D. 9 West 11th St #4 Frederick, Md		
31. DATE FILED (Month, Day, Year): DEC 28 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lucille Edith Porter				2. DATE OF DEATH (Month, Day, Year): 11 28 89	3. TIME OF DEATH: 21:44 P.M.
4. SOCIAL SECURITY NUMBER: 215-14-2146	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 15, 1921	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Knoxville			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 3628 Petersville Road		10f. ZIP CODE: 21758		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife		16b. KIND OF BUSINESS/INDUSTRY: Homemaker	
17. FATHER'S NAME (First, Middle, Last): Karl Hunter Eddins				18. MOTHER'S NAME (First, Middle, Maiden Surname): Bertha Lee Landis	
19a. INFORMANT'S NAME (Type/Print): Burgess C. Porter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3628 Petersville Rd. - Knoxville, MD 21758			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithburg Crematory		20c. LOCATION — City or Town, State: Smithburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home Brunswick, MD 21716			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Status Asthmaticus	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James S. Grissom M.D.	D 21944	▶ 11/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James S. Grissom, M. D. - 1475 Taney Ave. - Frederick, MD 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 05 1989	Julia Davidson-Randall

OHMH-16 Rev 1/89

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89 37695

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) EVELYN Evelyn Grace POTTS POTTS				2. DATE OF DEATH MONTH 12 DAY 28 YEAR 89	3. TIME OF DEATH 12:25 PM
4. SOCIAL SECURITY NUMBER 218 - 01 - 9378	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 80 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) July 23,1909	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Easton	9c. COUNTY OF DEATH Talbot

RESIDENCE OF DECEDENT

10a. STATE Maryland MD	10b. COUNTY Queen Anne's	10c. CITY, TOWN OR LOCATION Centreville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER R.D. 2, Box 55	10f. ZIP CODE 21617	10g. CITIZEN OF WHAT COUNTRY? United States	

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 7 College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress	16b. KIND OF BUSINESS/INDUSTRY Garment	
17. FATHER'S NAME (First, Middle, Last) Marion Emmit Potts		18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara - Stanton	
19a. INFORMANT'S NAME (Type/Print) Niece Joyce B. Tolson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) R.D.2, Box 55, Centreville, MD 21617	
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/30/89		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Chesterfield Cemetery	20c. LOCATION — City or Town, State Centreville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James H. Barton, Jr. James H. Barton, Jr.		22. NAME AND ADDRESS OF FACILITY Barton Funeral Home P.O. Box 222, Centreville, MD. 21617	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. shock	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. prob. ruptured abd. aneurysm	60 min.
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Charles E. DiNapoli MD	29c. LICENSE NUMBER D38990	29d. DATE SIGNED (Month, Day, Year) 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles E. DiNapoli MD	404 Marvel Court EASTON, MD 21601	
31. DATE FILED (Month, Day, Year) 12/28/89	32. REGISTRAR'S SIGNATURE Judith Davidson-Rinaldi	

DHMH-18 Rev 1/89

89 37696

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2-3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Rinaldo Dimitri Pannell
2. DATE OF DEATH — MONTH: 12 DAY: 27 YEAR: 89
3. TIME OF DEATH: 12:29 AM
4. SOCIAL SECURITY NUMBER: 579-72-9934
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 36 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 5/26/53
8. BIRTHPLACE (State or Foreign Country): Washington, D.C.
9a. FACILITY NAME (If not institution, give street and number): 2111 Alice Ave
9b. CITY, TOWN OR LOCATION OF DEATH: Oxon Hill
9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Oxon Hill
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2111 Alice Avenue
10f. ZIP CODE: 20745
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+): 4
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Personnel Specialist
16b. KIND OF BUSINESS/INDUSTRY: Federal Government
17. FATHER'S NAME (First, Middle, Last): Roland Hayes Pannell
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Alberta Brown
19a. INFORMANT'S NAME (Type/Print): Veronica Randall
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3410 Gateshead Manorway Silver Sprng., Md. 20904
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Maryland Nat. Cemetery
20c. LOCATION — City or Town, State: Laurel, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Lee G. Waller
22. NAME AND ADDRESS OF FACILITY: R.N. Horton Co. Morticians, Inc. 600 Kennedy Street N.W. D.C. 20011

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio Pulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Hypertensive arteric Sclerotic Cardio vascular Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus - Insulin Dependent; Gouty Arthritis
24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Linda Whitby MD
29c. LICENSE NUMBER: D17162
29d. DATE SIGNED (Month, Day, Year): ▶ 12/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): LINDA Whitby MD 9556 CRAIN Hwy Upper Marlboro, MD 20772
31. DATE FILED (Month, Day, Year): JAN 5 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 37697

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Angeliki PAPPAS			2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 89	3. TIME OF DEATH: 10:58 P M
4. SOCIAL SECURITY NUMBER: 109-30-6314	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-11-20	8. BIRTHPLACE (State or Foreign Country): ALBANIA
9a. FACILITY NAME (If not institution, give street and number): Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Silver Spring, MD		9c. COUNTY OF DEATH: Montgomery
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 9412 Warren St		10f. ZIP CODE: 20910		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: own home
17. FATHER'S NAME (First, Middle, Last): Athanasios Stavrou			18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Dakos	
19a. INFORMANT'S NAME (Type/Print): James Pappas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 320B Parsonsburg, Md. 21849		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven cemetery		20c. LOCATION — City or Town, State: Silver Spring, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Hines/Rinaldi Funeral Home 11800 N.H. Ave., Silver Spring, Md. 20904		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	SEPTICEMIA	1 DAY
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	METASTATIC CANCER	many
DUE TO (OR AS A CONSEQUENCE OF):		
c.	BREAST CANCER	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Stanley A Schwartz	D17368	▶ 12/31/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Stanley A. Schwartz, MD 2101 Medical Park Dr., #211 Silver Spring, Md.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 4 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

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89 37698

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Gary Everett RUSSELL				2. DATE OF DEATH (Month, Day, Year): December 22, 1989	3. TIME OF DEATH: 1:30p M
4. SOCIAL SECURITY NUMBER: 563-72-7590	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 38 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): December 11, 1951	8. BIRTHPLACE (State or Foreign Country): California
9a. FACILITY NAME (If not institution, give street and number): 5305 Beulah Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Ijamsville		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Ijamsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5305 Beulah Drive		10f. ZIP CODE: 21754	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam 1974-1977	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] ND Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Software engineering	16b. KIND OF BUSINESS/INDUSTRY: Computers
17. FATHER'S NAME (First, Middle, Last): Walter Everett Russell		18. MOTHER'S NAME (First, Middle, Maiden Surname): Joan Raub	
19a. INFORMANT'S NAME (Type/Print): Cathy Marie Russell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5303 Beulah Drive, Ijamsville, Maryland 21754	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory	20c. LOCATION — City or Town, State: Smithsburg, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Kathlynn Robeson M00706		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 E. Church St., Frederick, MD. 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MALIGNANT LEIOMYOSARCOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 5 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Gerald Winnan MD	D25151	▶ 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Gerald Winnan, M.D., 310 West Ninth Street, Frederick, Maryland 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37699

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Goldie J. Rice
2. DATE OF DEATH (Month, Day, Year): Nov. 29, 1989
3. TIME OF DEATH: 8:45 a. M
4. SOCIAL SECURITY NUMBER: 215-36-5832-A
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 92 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Feb. 13, 1897
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 10124 Bethel Road
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: 10124 Bethel Road Frederick
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 10124 Bethel Road
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 years — College (1-4 or 5+): - - - - -
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): H omemaker
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): Joshua A. L. Rice
18. MOTHER'S NAME (First, Middle, Maiden Surname): Frances E. Moser
19a. INFORMANT'S NAME (Type/Print): Lawrence Rice
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10124 Bethel Rd., Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dunkard Brethren Cemetery
20c. LOCATION — City or Town, State: Mountaindale, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert W. Keeney M00652
22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 E. Church St., Fred. Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ~~Asthma~~	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ~~Asthma~~

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER: D15804
29d. DATE SIGNED (Month, Day, Year): ▶ 11/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Steven A. Pickert M.D. 100 S. Center St., Thurmont, Md. 21788

31. DATE FILED (Month, Day, Year): DEC 01 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37700

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RUTH ROBBINS						2. DATE OF DEATH (Month, Day, Year): 12 15 89		3. TIME OF DEATH: 9 35PM M
4. SOCIAL SECURITY NUMBER: 253-30-7874	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		7. DATE OF BIRTH (Month, Day, Year): 12 05 28		8. BIRTHPLACE (State or Foreign Country): Atlanta GA.
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY			9c. COUNTY OF DEATH: PRINCE GEORGES	
RESIDENCE OF DECEDENT								
10a. STATE: MD.	10b. COUNTY: Prince Georges		10c. CITY, TOWN OR LOCATION: Landover				10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 2000 Ray Leonard Rd				10f. ZIP CODE: 20785			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEOENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Clerk			16b. KIND OF BUSINESS/INDUSTRY: Government			
17. FATHER'S NAME (First, Middle, Last): James Smith				18. MOTHER'S NAME (First, Middle, Maiden Surname): Rosa Lee				
19a. INFORMANT'S NAME (Type/Print): Rosie Annette Milnor			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8208 Kilmory Ct., Severn, MD. 21144					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Mem. Cemetery			20c. LOCATION — City or Town, State: Landover, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward Strickland			22. NAME AND ADDRESS OF FACILITY: Funeral Serv. Assoc. 1425 Maryland Ave NE, Wash. DC					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST - VENTRICULAR FIBRILLATION

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. END STAGE CARDIOMYOPATHY.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ANOXIC ENCEPHALOPATHY.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D22910	▶ 12.19.89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ASIF S. QADRI. 4700, BERWYN HOUSE RD, COLLEGE PK MD 20740.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 31 1990	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37701

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ronald David RICE, SR.		2. DATE OF DEATH (Month, Day, Year): December 11, 1989	3. TIME OF DEATH: 3:30 p M
4. SOCIAL SECURITY NUMBER: 220-54-4319	5. SEX: 1 XX M 2 ☐ F	6. AGE (In yrs. last birthday): 38 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 19, 1951
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): 6194 Viewsite Court	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATIDN: Frederick	10d. INSIOE CITY LIMITS? 1 ☐ YES 2 X ND
10e. STREET AND NUMBER: 6194 Viewsite Court	10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FDRCES? 1 ☐ YES 2 X NO IF YES, OIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC DRIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Bricklayer	16b. KIND OF BUSINESS/INDOUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Earl Rice	18. MOTHER'S NAME (First, Middle, Maiden Surname): Edna V. Bidle		
19a. INFORMANT'S NAME (Type/Print): Mrs. Patricia E. Rice	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6194 Viewsite Court, Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Allan H Ruby M00703	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home, 21701 106 East Church Street, Frederick, Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. metastatic melanoma

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X ND	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X ND

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF OEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATIDN (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D14C7C	29d. DATE SIGNED (Month, Day, Year): ▶ 12/12/89

30. NAME AND AOORESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. P. Gregory Rausch, M.D., 501 West Seventh Street, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): DEC 12 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37702

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Reginald Schneider / Reginald Schneider			2. DATE OF DEATH (Month, Day, Year): 12 25 89	3. TIME OF DEATH: 1311 M
4. SOCIAL SECURITY NUMBER: 214-28-8096	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 9- 16- 1906	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): DORCHESTER HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: CAMBRIDGE		9c. COUNTY OF DEATH: DORCESTER

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: SALISBURY	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 305 MIDDLE BLVD.		10f. ZIP CODE: 21801	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: NAVY WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): UNK; College (1-4 or 5+): 2 YEARS	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DISTRIBUTOR	16b. KIND OF BUSINESS/INDUSTRY: PROPANE	
17. FATHER'S NAME (First, Middle, Last): WALTER --- CATLIN		18. MOTHER'S NAME (First, Middle, Maiden Surname): KATHERINE UNK	
19a. INFORMANT'S NAME (Type/Print): WILLIAM SCHNEIDER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PO BOX 1094, SALISBURY, MD 21801	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) 12/28/89	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): WICOMICO MEMORIAL PARK	20c. LOCATION — City or Town, State: SALISBURY, MD 21801	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John M. Holloway		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ReFractory Ventricular Arrhythmias	
	DUE TO (OR AS A CONSEQUENCE OF): coronary Artery Disease-presumed	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Coronary Artery disease - presumed	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [ ] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michael J Fadden / Michael J Fadden MD	29c. LICENSE NUMBER: D26388	29d. DATE SIGNED (Month, Day, Year): 12/25/89 / 12/25/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 302 Collins Hurlock Md 21643 (302 Collins) Hurlock, Md 21643			
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: [signature]		

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37703

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Velma R. Simonetti			2. DATE OF DEATH (Month / Day / Year): 12/20/89	3. TIME OF DEATH: 5 PM
4. SOCIAL SECURITY NUMBER: 578-44-1950	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 75 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): Nov. 1, 1914	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Leland Mem. Hosp.		9b. CITY, TOWN OR LOCATION OF DEATH: Riverdale		9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Prince George's	10c. CITY, TOWN OR LOCATION: Mt. Rainier	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 4600 - 30th St.		10f. ZIP CODE: 20712	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Jacob Hammann		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jo Ann Hartley	
19a. INFORMANT'S NAME (Type/Print): Jacob W. Gassaway		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5763 Detrick Rd., Mt. Airy, Md. 21771	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Forest Oak Cemetery	20c. LOCATION — City or Town, State: Gaithersburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Olin L. Molesworth		22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypothermia DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: None

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12/18/89	28b. TIME OF INJURY: — M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Hypothermia at home
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 4600 - 30th St. Mt. Rainier, Md.

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John S. Rogers M.D.	29c. LICENSE NUMBER: D09975	29d. DATE SIGNED (Month, Day, Year): Dec 20 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John S. Rogers, M.D. 1919 Seminary Road, Silver Spring, Md. 20910		
31. DATE FILED (Month, Day, Year): DEC 26 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37704

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Smith, Russell- Russell Marshall SMITH
2. DATE OF DEATH (Month, Day, Year): 12-2-89
3. TIME OF DEATH: 10:29am
4. SOCIAL SECURITY NUMBER: 219-20-0279
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 77 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Oct. 7, 1912
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: olney
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Howard
10c. CITY, TOWN OR LOCATION: Woodbine
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 1661 Route 94
10f. ZIP CODE: 21797
10g. CITIZEN OF WHAT COUNTRY?: American
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: World War II
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Farmer
16b. KIND OF BUSINESS/INDUSTRY: Farming
17. FATHER'S NAME (First, Middle, Last): Marshall Smith
18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie (unknown)
19a. INFORMANT'S NAME (Type/Print): Nellis L. Smith
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1661 Route 94, Woodbine, Maryland 21797
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Crest Lawn Mem. Gardens
20c. LOCATION — City or Town, State: Marriottsville Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Williams
22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A., Funeral Home Damascus, Maryland 20872-0117

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PERFORATED DUODENAL ULCER — Approximate Interval Between Onset and Death: Acute

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Richard Dadley MD
29c. LICENSE NUMBER: D16458
29d. DATE SIGNED (Month, Day, Year): ▶ Dec 2, 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print): Richard E. Dadley MD 17904 Georgia Ave Olney, Md 20832
31. DATE FILED (Month, Day, Year): DEC 04 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37705

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

SMITH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Robert Lee SMITH			2. DATE OF DEATH (Month, Day, Year): December 28, 1989	3. TIME OF DEATH: 5:15 a M
4. SOCIAL SECURITY NUMBER: 214-10-3627	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 99 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 23, 1890	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 203 West Second Street		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): District Manager	16b. KIND OF BUSINESS/INDUSTRY: Electric Power Company	
17. FATHER'S NAME (First, Middle, Last): Charles Edward Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Florence Burnetta Smith		
19a. INFORMANT'S NAME (Type/Print): Mr. Robert L. Smith, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 203 West Second Street, Frederick, Maryland 21701		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Keith Lynn Roberson M00706		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cerebrovascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pernicious anemia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) / 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Austin Pearre JR.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 12/28/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Austin A. Pearre, Jr., MD 300 West Ninth Street, Frederick, Maryland 21701		
31. DATE FILED (Month, Day, Year): DEC 28 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

89 37706

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary Kurtz Stevenson			2. DATE OF DEATH (Month, Day, Year): Nov. 28, 1989	3. TIME OF DEATH: 7:20 A. M
4. SOCIAL SECURITY NUMBER: 220-20-6761	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Aug. 6, 1926	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Olney		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Damascus	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 26630 Haney Ave.		10f. ZIP CODE: 20872	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Hubert P. Kurtz		18. MOTHER'S NAME (First, Middle, Maiden Surname): Jennie Mae Kershaw	
19a. INFORMANT'S NAME (Type/Print): Robert H. Stevenson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 26630 Haney Ave., Damascus, Md. 20872	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Gate of Heaven Cemetery	20c. LOCATION — City or Town, State: Silver Spring, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth		22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myelodysplastic syndrome (Refractory anemia with excess of leukemic blasts) — 2 yrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Terminal sepsis, immune compromised host, underlying nine yr history bilateral breast cancer with bone metastasis, pancytopenia.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald E. Dillon MD	29c. LICENSE NUMBER: D13632	29d. DATE SIGNED (Month, Day, Year): ▶ Nov. 28, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald E. Dillon, M.D. 2901 Olney-Sandy Spring Rd., Olney, Md. 20832		
31. DATE FILED (Month, Day, Year): DEC 04 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

89 37707

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Thomas Edward STALEY, Sr. — THOMAS EDWARD STALEY SR.
2. DATE OF DEATH: MONTH 11, DAY 29, YEAR 1989
3. TIME OF DEATH: 1955 M
4. SOCIAL SECURITY NUMBER: 218-30-9277
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 55 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 14, 1934
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 8536 Rocky Springs Road
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): News Paper Distributor
16b. KIND OF BUSINESS/INDUSTRY: Distuibutor of newspapers
17. FATHER'S NAME (First, Middle, Last): Carl Clifford Staley, Sr.
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Burger
19a. INFORMANT'S NAME (Type/Print): Mrs. Audrey L. Staley
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8536 Rocky Springs Rd., Frederick, Md. 21701
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery
20c. LOCATION — City or Town, State: Frederick, Maryland 21701
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard C. C. Basford M00021
22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home, 106 East Church St., Frederick, Md. 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. TERMINAL METASTATIC Lung cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 8 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur G. Manalo, M.D.
29c. LICENSE NUMBER: D-18191
29d. DATE SIGNED (Month, Day, Year): ▶ 11/29/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Arthur G. Manalo, M.D. 189 Thomas Johnson Dr. Frederick MD. 21701
31. DATE FILED (Month, Day, Year): DEC 01 1989
32. REGISTRAR'S SIGNATURE: Julia [illegible] Kindell

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DNMH-18 Rev 1/89

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89 37708

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Orpha May Sigler			2. DATE OF DEATH (Month, Day, Year): Dec. 17, 1989	3. TIME OF DEATH: 10:00 P. M
4. SOCIAL SECURITY NUMBER: 215-21-3533	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 10, 1904	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Middletown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 7029 Mt. Church Rd.		10f. ZIP CODE: 21769	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 5 — College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): housewife	16b. KIND OF BUSINESS/INDUSTRY: own home		
17. FATHER'S NAME (First, Middle, Last): Edgar Rohrback		18. MOTHER'S NAME (First, Middle, Maiden Surname): Esta Fink		
19a. INFORMANT'S NAME (Type/Print): J. Warren Sigler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Mt. Church Rd., Middletown, Md. 21769		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Locust Valley Cemetery	20c. LOCATION — City or Town, State: Middletown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home 31 E. Main St., Middletown, Md. 21769		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Hypotension → Shock	1 day
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Sepsis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Michael Behre MD	D16939	▶ 12/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Michael Behre (Middletown Md)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 20 1989	[signature]

DHMH-16 Rev 1/89

89 37709

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harry F. Starner, III			2. DATE OF DEATH (Month, Day, Year): December 17, 1989	3. TIME OF DEATH: 2 A M
4. SOCIAL SECURITY NUMBER: 579-24-6730	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 63 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 1/7/26	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 13407 Grenoble Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville		9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? [ ] YES [X] NO
10e. STREET AND NUMBER: 13407 Grenoble Drive	10f. ZIP CODE: 20853	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Security Guard	16b. KIND OF BUSINESS/INDUSTRY: None	
17. FATHER'S NAME (First, Middle, Last): Harry Franklin Starner, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Louise Virginia Albaugh	
19a. INFORMANT'S NAME (Type/Print): Harry F. Starner, IV		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4908 42nd Place Hyattsville, MD 20781	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg, Crematory	20c. LOCATION — City or Town, State: Smithsburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey	22. NAME AND ADDRESS OF FACILITY: Robert E. Dailey & Son Funeral Homes, PA 1201 N. Market Street Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCTION	MINUTES
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE	YEARS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: ASTHMA

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Paul A. DeVore Deputy Medical Examiner	29c. LICENSE NUMBER: D01852	29d. DATE SIGNED (Month, Day, Year): 12/17/89	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PAUL A. DEVORE M.D. 4203 Queensbury Rd Hyattsville MD 20781			
31. DATE FILED (Month, Day, Year): DEC 19 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

89 37710

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mabel Louise SHANKLE			2. DATE OF DEATH (Month, Day, Year): December 5, 1989	3. TIME OF DEATH: 12:07 M
4. SOCIAL SECURITY NUMBER: 215-26-8379	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): August 29, 1929	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 1817 Lawnview Drive		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 105 East Seventh Street		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 College (1-4 or 5 +):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Dorsey G. Cook		18. MOTHER'S NAME (First, Middle, Maiden Surname): Carrie E. Cramer		
19a. INFORMANT'S NAME (Type/Print): Donald W. Shankle		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1817 Lawnview Drive, Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens		20c. LOCATION — City or Town, State: Frederick, Md. 21701
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Richard C. C. Basford M00021		22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home 106 East Church Street, Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic ovarian cancer	6 months
	OUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	OUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Charles R. Clark M.D.	D-19029 (Maryland)	12/7/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Charles R. Clark, M.D. 56 Thomas Johnson Drive, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 07 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37711

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beatrice / BEATRICE W. STOTTLEMYER / Stottlemyer		2. DATE OF DEATH (Month - Day - Year): 12 - 04 - 89	3. TIME OF DEATH: 16:59 P.M.
4. SOCIAL SECURITY NUMBER: 214-32-4138	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 73 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/19/16
8. BIRTHPLACE (State or Foreign Country): MD.			
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: New Market	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 10901 Old National Pike	10f. ZIP CODE: 21774	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cafeteria worker	16b. KIND OF BUSINESS/INDUSTRY: Buffeteria Montgomery Wards	
17. FATHER'S NAME (First, Middle, Last): Luckett Wolfe	18. MOTHER'S NAME (First, Middle, Maiden Surname): Claudia Smith Wolfe		
19a. INFORMANT'S NAME (Type/Print): Julia Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1119 Virginia Ave., Hagerstown, Md. 21740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer	22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction — 10 min

DUE TO (OR AS A CONSEQUENCE OF): Acute Myocardial Infarction + Arrhythmia

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): & Arrhythmia

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA — OTHER: 4 ☐ Nursing Home 5 ☒ Residence 8 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert L. Kaufman, MD	29c. LICENSE NUMBER: D-13971	29d. DATE SIGNED (Month, Day, Year): ▶ 12/4/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): DEC 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37712

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): George Kenneth Smith			2. DATE OF DEATH (Month, Day, Year): Dec 28, 1989	3. TIME OF DEATH: 2:50 P M
4. SOCIAL SECURITY NUMBER: 043-03-6300	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): 8/26/1920	8. BIRTHPLACE (State or Foreign Country): England
9a. FACILITY NAME (If not institution, give street and number): Bonnie Brook Road		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Bonnie Brook Road		10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Musician	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Thomas Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ada Cooper	
19a. INFORMANT'S NAME (Type/Print): Eric C. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8961 State Rt 736 Plain City, Ohio 43064	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Crematory	20c. LOCATION — City or Town, State: Salisbury, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Thomas Funeral Home 700 Locust St. Cambridge, Md. 21613	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-28-89	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] Deputy Medical Examiner		29c. LICENSE NUMBER: D23207	29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Raul Diaz, M.D. 200 Maryland Ave. Cambridge, 21613			
31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SIIIC 89

89 37713

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ROBERT Greer Sansbury			2. DATE OF DEATH (Month, Day, Year): 12 24 '89	3. TIME OF DEATH: 7:30P M
4. SOCIAL SECURITY NUMBER: 578-12-4182	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11 / 29 /20	8. BIRTHPLACE (State or Foreign Country): Va
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE	
RESIDENCE OF DECEDENT				
10a. STATE: Md	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Catonsville	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: Catonsville State Spring Grove Hospital		10f. ZIP CODE: 21228	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10; College (1-4 or 5+): 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): Wallace T. Sansbury		18. MOTHER'S NAME (First, Middle, Maiden Surname): Helen C. Greer		
19a. INFORMANT'S NAME (Type/Print): Deloris Cook		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7901 Carol Ct.,Clinton,Md. 20735		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lee Crematory	20c. LOCATION — City or Town, State: Clinton,Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Lee Funeral Home,Inc. 6633 Old Alexander Ferry Road Clinton,Md. 20735		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIAC ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: James L. Miller MD

29c. LICENSE NUMBER

29d. DATE SIGNED (Month, Day, Year): ▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): j. miller,m.d.-GREATER BALTIMORE MEDICAL CENTER-6701 N.CHARLES ST.

31. DATE FILED (Month, Day, Year): JAN 10 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37714

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Florence Virginia Settles
2. DATE OF DEATH (Month, Day, Year): Dec. 30, 1989
3. TIME OF DEATH: 8:10 p M
4. SOCIAL SECURITY NUMBER: 214-09-4635
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (If under 1 year, last birthday): 74 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): March 14, 1915
8. BIRTHPLACE (State or Foreign Country): Maryland
8a. FACILITY NAME (If not institution, give street and number): Washington County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Hagerstown
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 107 D Hunterhill Dr.
10f. ZIP CODE: 21740
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY: Home
17. FATHER'S NAME (First, Middle, Last): Harry E. Osborne
18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida B. Bowers
19a. INFORMANT'S NAME (Type/Print): Carolyn L. English
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 178 Keedysville, MD 21756
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Riverview Cemetery
20c. LOCATION — City or Town, State: Williamsport, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis L Davis
22. NAME AND ADDRESS OF FACILITY: Davis Funeral Home, Rt. 3 Box 78 Smithsburg, MD 21783

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Acute Recurrent Ventricular Fibrillation	one day
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic Coronary vessel disease	10 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Brull Personal Physician
29c. LICENSE NUMBER: D04359
29d. DATE SIGNED (Month, Day, Year): 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert Brull 1459 Potomac Ave. Hagerstown
31. DATE FILED (Month, Day, Year): JAN 02 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37715

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Helen Louise Seavolt	2. DATE OF DEATH (Month, Day, Year): Dec 30 1989	3. TIME OF DEATH: 0715 PM
4. SOCIAL SECURITY NUMBER: 215-12-2337	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-30-1921	8. BIRTHPLACE (State or Foreign Country): PA.
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON CO. HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN	9c. COUNTY OF DEATH: WASHINGTON CO.

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: WASHINGTON CO.	10c. CITY, TOWN OR LOCATION: HAGERSTOWN	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RT. 2 BOX 153	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): HOMEMAKER	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): JACOB E. POWELL	18. MOTHER'S NAME (First, Middle, Maiden Surname): HARRIET A. HEPLER	
19a. INFORMANT'S NAME (Type/Print): RONALD SEAVOLT	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RT. 1 BOX 451 CLEARSPRING MD. 21722	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): OLD TONOLOWAY BAPTIST CEM.	20c. LOCATION — City or Town, State: HANCOCK, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis L. Davis	22. NAME AND ADDRESS OF FACILITY: THOMPSON FUNERAL HOME INC. PO BOX 310 CLEARSPRING MD. 21722	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adeno Carcinoma left Breast with DUE TO (OR AS A CONSEQUENCE OF):	18 MOS
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Bone Metastasis DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W. Dittoe III MD	29c. LICENSE NUMBER: D0 1062	29d. DATE SIGNED (Month, Day, Year): ▶ Dec 31, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Dittoe III MD 217 W. Washington St Hagerstown, MD 21740		
31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37716

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TRAVIS WILLIAM SHANK
2. DATE OF DEATH — MONTH: December DAY: 30, YEAR: 1989
3. TIME OF DEATH: 4:19A. M
4. SOCIAL SECURITY NUMBER: NONE
5. SEX: 1 XX M 2 ☐ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 8 / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12-29-1989
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown
9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Washington
10c. CITY, TOWN OR LOCATION: Cavetown
10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: P.O. Box 32
10f. ZIP CODE: 21720
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): / College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE
16b. KIND OF BUSINESS/INDUSTRY: NONE
17. FATHER'S NAME (First, Middle, Last): William Luther Shank
18. MOTHER'S NAME (First, Middle, Maiden Surname): Regina J. Landers
19a. INFORMANT'S NAME (Type/Print): Virginia B. Hartman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 32, Cavetown, Maryland 21720
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Lawn Memorial Park
20c. LOCATION — City or Town, State: Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Dennis L Davis
22. NAME AND ADDRESS OF FACILITY: Davis Funeral Home, Rt 3 Box 78, Smithsburg, Maryland 21783

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Perinatal Asphyxia — Approximate Interval: 8 hours
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Meconium Aspiration; Sub Galeal Hematoma

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: James M. Pribula MD
29c. LICENSE NUMBER: 035238
29d. DATE SIGNED (Month, Day, Year): 1/3/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James M. Pribula 324 E. Antietam St. Hagerstown, Md. 21740
31. DATE FILED (Month, Day, Year): JAN 10 '90
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 & 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ellen B. STEVENSON			2. DATE OF DEATH (Month, Day, Year): Dec. 25, 1989	3. TIME OF DEATH: 6:40 P M
4. SOCIAL SECURITY NUMBER: 218-12-1452	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 68 69 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-29-20	8. BIRTHPLACE (State or Foreign Country): M.D.
9a. FACILITY NAME (If not institution, give street and number): Deer's Head Center		9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury, Md. 21801		9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: M.D.	10b. COUNTY: Somerset	10c. CITY, TOWN OR LOCATION: Pr. Anne M.D.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: P.O.B. 562- Pr. Anne Md.		10f. ZIP CODE: 21853	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Blk.

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) X / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): retired	16b. KIND OF BUSINESS/INDUSTRY: Resturant	
17. FATHER'S NAME (First, Middle, Last): Hampton Doane		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ellen Bell Doane	
19a. INFORMANT'S NAME (Type/Print): Joyce Ann Stevenson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PoB. 562- Pr. Anne M.D. 21853	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Hope Cemetery	20c. LOCATION — City or Town, State: Pr. Anne Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Russell A. Fooks		22. NAME AND ADDRESS OF FACILITY: Fooks Funeral Home P.O.B. 1574 Salisbury Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Recurrent C.V.A. and comotose state	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Diabetes Mellitus

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M. Shrestha MD	29c. LICENSE NUMBER: D16278	29d. DATE SIGNED (Month, Day, Year) ▶ 12.25.89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maheswari Shrestha, M.D.; P.O. Box 2018; Salisbury, Md. 21802		
31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Shrestha	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bonnie Lee Stoakley

2. DATE OF DEATH (Month, Day, Year): 12 29 89

3. TIME OF DEATH: 0810 M

4. SOCIAL SECURITY NUMBER: 218-40-5653

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 48 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 09-29-41

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): 118 Cardinal Drive

9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury

9c. COUNTY OF DEATH: Wicomico

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: Wicomico

10c. CITY, TOWN OR LOCATION: Salisbury

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: Rt. 4 118 Cardinal Dr.

10f. ZIP CODE: 21801

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc.
Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 12
College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Resource Assistant

16b. KIND OF BUSINESS/INDUSTRY: Wicomico County Bd. Of Education

17. FATHER'S NAME (First, Middle, Last): Page P. Chesser

18. MOTHER'S NAME (First, Middle, Maiden Surname): Ann Rae evans Jones

19a. INFORMANT'S NAME (Type/Print): Dana L. Stoakley

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 4 118 Cardinal Dr. Salisbury, MD 21801

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) _____

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Stephens Cemetery

20c. LOCATION — City or Town, State: Delmar, Delaware

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ B. Keith Phoppert

22. NAME AND ADDRESS OF FACILITY: Bounds Funeral Home Salisbury, MD

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Hypertensive Cardiovascular Disease
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: John T. Bulkeley Deputy M.E.

29c. LICENSE NUMBER: D03599

29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John T. Bulkeley, M.D. - Salisbury, Maryland

31. DATE FILED (Month, Day, Year): JAN 2 '90

32. REGISTRAR'S SIGNATURE: Julia Davidson Rundell

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DHMH-16 Rev 1/89

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DAISY MAE TOWNSEND				2. DATE OF DEATH (Month, Day, Year): 12 17 89	3. TIME OF DEATH: 1:12 P M
4. SOCIAL SECURITY NUMBER: 219-07-9805	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 93 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 5-6-96	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): SALISBURY NURSING HOME			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MD.		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: FruitLand	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 202 Lesley St FruitLand	10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY?: USA	

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Blk

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6 / College (1-4 or 5+): —	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Domestic	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): GREENBRO BIVENS	18. MOTHER'S NAME (First, Middle, Maiden Surname): MALY BIVENS
19a. INFORMANT'S NAME (Type/Print): MARTHA COTTMAN	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 262 LESLEY ST FruitLAND

20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify):	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST MARYS CEMETERY	20c. LOCATION — City or Town, State: PT. ANNA Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Russell A Fox	22. NAME AND ADDRESS OF FACILITY: Fox F/H P.O. Box 574 Salisbury Md.	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiorespiratory Arrest	Immediate
DUE TO (OR AS A CONSEQUENCE OF): b.	Aspiration Pneumonitis	Hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — DUE TO (OR AS A CONSEQUENCE OF): c.	Pneumonia	Days
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Cerebrovascular Disease
Type II Diabetes Mellitus
Organic Brain Syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	29c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Mark Seaherd	29c. LICENSE NUMBER: D36708	29d. DATE SIGNED (Month, Day, Year): ▶ 12/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Pardell

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DHMH-16 Rev 1/89

89 37720

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDNA M. THOMAS		2. DATE OF DEATH (Month, Day, Year): DECEMBER 25, 1989	3. TIME OF DEATH: 2206 M
4. SOCIAL SECURITY NUMBER: 220-12-1084	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 63 63 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6-26-1926
8. BIRTHPLACE (State or Foreign Country): Md.			
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND	9c. COUNTY OF DEATH: WICOMICO	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Tyaskin	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 1 Box 90	10f. ZIP CODE: 21865	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Beautician	16b. KIND OF BUSINESS/INDUSTRY: -------	
17. FATHER'S NAME (First, Middle, Last): Arthur Farrington	18. MOTHER'S NAME (First, Middle, Maiden Surname): Esther Dashield		
19a. INFORMANT'S NAME (Type/Print): Elizabeth Tull	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt 1 Box 90, Tyaskin, Maryland 21865		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): New Town Cemetery	20c. LOCATION — City or Town, State: Tyaskin, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Cornelius D. Messick II	22. NAME AND ADDRESS OF FACILITY: Messick Funeral Home, P.O. Box 61 Bivalve, Maryland 21814		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Metastatic Lung Ca —	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☒ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D 20507	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 145 E. CARROLL ST SALISBURY MD		
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: [signature]	

6

DHMN-18 Rev 1/89

89 37721

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDDIE Lee L. THOMPSON			2. DATE OF DEATH (Month, Day, Year): 12 1 1989	3. TIME OF DEATH: 7:36 P M
4. SOCIAL SECURITY NUMBER: 215-64-1742	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 35 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Dec. 29, 1953	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Washington Co. Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Knoxville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 3922 South Mountain Road		10f. ZIP CODE: 21758		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Signal Maintainer		16b. KIND OF BUSINESS/INDUSTRY: CSX Railroad
17. FATHER'S NAME (First, Middle, Last): Theodore E. Thompson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Janice L. Shade		
19a. INFORMANT'S NAME (Type/Print): Mrs. Faith Thompson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3922 South Mountain Rd., Knoxville, Md. 21758		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery		20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Deaf M00255		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cranio-cerebral injuries

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-1-89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Operator of motorcycle that lost control
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Rt. 180 & Rt. 340, Frederick Co., MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James A. Kaplan, M.D. 111 Penn St., Balto., MD 21201

31. DATE FILED (Month, Day, Year): DEC 07 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37722

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JONAH JOSEPH TRESSLER			2. DATE OF DEATH (Month, Day, Year): DECEMBER 19, 1989	3. TIME OF DEATH: ~1100 A M
4. SOCIAL SECURITY NUMBER: 196-18-7060	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): May 12, 1911	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): 7819-C FRIENDS CREEK ROAD		9b. CITY, TOWN OR LOCATION OF DEATH: EMMITSBURG,		9c. COUNTY OF DEATH: FREDERICK

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: FREDERICK	10c. CITY, TOWN OR LOCATION: EMMITSBURG,	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 7819-C FRIENDS CREEK ROAD		10f. ZIP CODE: 21727	10g. CITIZEN OF WHAT COUNTRY?: U. S. A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): FARMER	16b. KIND OF BUSINESS/INDUSTRY: FARMING	
17. FATHER'S NAME (First, Middle, Last): JOSEPH B. TRESSLER		18. MOTHER'S NAME (First, Middle, Maiden Surname): CARRIE VIRGINIA BROWN	
19a. INFORMANT'S NAME (Type/Print): FLORENCE R. TRESSLER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7819-C FRIENDS CREEK RD. EMMITSBURG, MD 21727	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FRIENDS CREEK CHURCH OF GOD	20c. LOCATION — City or Town, State: EMMITSBURG, MD 21727
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John M. Skiles		22. NAME AND ADDRESS OF FACILITY: SKILES FUNERAL HOME 210 W. MAIN ST. , EMMITSBURG, MD 21727	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Congestive Heart Failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Atherosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Alan Carroll MD	29c. LICENSE NUMBER: D18705	29d. DATE SIGNED (Month, Day, Year): ▶ 12/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ALAN CARROLL, M.D. S. SETON AVE. EMMITSBURG, MD. 21727		
31. DATE FILED (Month, Day, Year): DEC 21 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37723

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages ... should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARSHALL PETER TRADER				2. DATE OF DEATH (Month, Day, Year): 12 28 89	3. TIME OF DEATH: 1835 M
4. SOCIAL SECURITY NUMBER: 230-48-1311	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12-18-1937	8. BIRTHPLACE (State or Foreign Country): VIRGINIA
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: WORCESTER	10c. CITY, TOWN OR LOCATION: STOCKTON	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5907 GEORGE Islanding Rd.		10f. ZIP CODE: 21864	10g. CITIZEN OF WHAT COUNTRY?: U.S.A

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify: White	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): MECHANIC	16b. KIND OF BUSINESS/INDUSTRY: POULTRY PLANT	
17. FATHER'S NAME (First, Middle, Last): EDWARD L. TRADER		18. MOTHER'S NAME (First, Middle, Maiden Surname): LOTTIE DAVIS KILLMON	
19a. INFORMANT'S NAME (Type/Print): EVELYN T. HUBBARD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 82 EAST NEW MARKET, Md. 21631	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): BELLE HAVEN CEMETERY	20c. LOCATION — City or Town, State: BELLE HAVEN, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R.C. Doughty Jr.		22. NAME AND ADDRESS OF FACILITY: Doughty Funeral Home, INC P.O. Box 633 Exmore VA. 23350	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. PNEUMONIA	1 WK.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: METASTATIC OAT CELL CANCER

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert Allen, M.D.	29c. LICENSE NUMBER: D29168	29d. DATE SIGNED (Month, Day, Year) ▶ 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ROBERT ALLEN 560 RIVERSIDE DR. SALISBURY, MD. 21801

31. DATE FILED (Month, Day, Year): JAN 5 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondelle

1

DHMH-16 Rev 1/89

89 37724

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CHARLOTTE PATRICIA THOMPSON / Charlotte P. Thompson			2. DATE OF DEATH (Month, Day, Year): 12 19 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 104-10-1093	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): June 8, 1912	8. BIRTHPLACE (State or Foreign Country): Ireland
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1906 Lexington Avenue		10f. ZIP CODE: 21740		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Production Worker		16b. KIND OF BUSINESS/INDUSTRY: General Motors
17. FATHER'S NAME (First, Middle, Last): Esekiel Thompson		18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Gallagher		
19a. INFORMANT'S NAME (Type/Print): Kathleen Baker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28 Sycamore Drive, Avon, N.Y. 14414		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Holy Sepulchre Cemetery		20c. LOCATION — City or Town, State: Rochester, Monroe, Ny
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ R. Keel Brady		22. NAME AND ADDRESS OF FACILITY: Andrew K. Coffman Funeral Home, Inc. 40 E. Antietam Street, Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest · Possible Myocardial infarct
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Arteriosclerotic Heart Disease
DUE TO (OR AS A CONSEQUENCE OF):
c. Arteriosclerosis generalized
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Diabetes Mellitus - Recent viral gastro-enteritis with vomiting and hypokalemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] M.D.	29c. LICENSE NUMBER: D 042162	29d. DATE SIGNED (Month, Day, Year): ▶ 12-20-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Wm. N. Fowler, M.D. 138 E. Antietam St. Hagerstown Md 21740		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37725

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frances Keefer Thomas		2. DATE OF DEATH (Month, Day, Year): 12 28 1989	3. TIME OF DEATH: 10:15 a M
4. SOCIAL SECURITY NUMBER: 214-16-0505	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 93 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 8, 1896
8. BIRTHPLACE (State or Foreign Country): Maryland			
9a. FACILITY NAME (If not institution, give street and number): Western Maryland Hospital Center	9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown, Maryland	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 240 South Potomac Street	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary	16b. KIND OF BUSINESS/INDUSTRY: Gas Company	
17. FATHER'S NAME (First, Middle, Last): Samuel P. Thomas	18. MOTHER'S NAME (First, Middle, Maiden Surname): Laura V. Keefer		
19a. INFORMANT'S NAME (Type/Print): Geraldine Rogers	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 240 South Potomac St., Hagerstown, Md. 21740		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rose Hill Cemetery	20c. LOCATION — City or Town, State: Hagerstown, Wash., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: R. Noel Brady	22. NAME AND ADDRESS OF FACILITY: Andrew K. Coffman Funeral Home, Inc. 40 E. Antietam St., Hagerstown, Md. 21740		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. #428- Congestive Heart Failure	7 days
DUE TO (OR AS A CONSEQUENCE OF):		1 week
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. #485 - Bronchopneumonia and #586 - Renal Failure	2 weeks
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Intertrochanteric fracture left hip

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year): Oct. 6, 1989	28b. TIME OF INJURY: 2:00P M	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO	28d. DESCRIBE HOW INJURY OCCURED: Fell in bathroom at Sunshine Home
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Sunshine HOme			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 240 S. Potomac St., Hagerstown, Md.

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W. Ditto	29c. LICENSE NUMBER: D01062	29d. DATE SIGNED (Month, Day, Year): December 29, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Ditto, III, M.D., 217 West Washington Street, Hagerstown, Maryland 21740

31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Rondell

DHMH-16 Rev 1/89

89 37726

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Elwood L Temple			2. DATE OF DEATH (Month, Day, Year): 12 2 89	3. TIME OF DEATH: 10:58 A M
4. SOCIAL SECURITY NUMBER: 125-30-9105	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 83 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8 12 1906	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Denton		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 16 Heritage Court		10f. ZIP CODE: 21629		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II, Korean Conf.	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): graduated; College (1-4 or 5+): 2 M.A.	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Minister	16b. KIND OF BUSINESS/INDUSTRY: Religion		
17. FATHER'S NAME (First, Middle, Last): Leon Wilbur Temple		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Wegy		
19a. INFORMANT'S NAME (Type/Print): Susan Clark		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7526 Virginian Dr., Norfolk, Va 23505		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Denton Cemetery	20c. LOCATION — City or Town, State: Denton, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Randolph Moore	22. NAME AND ADDRESS OF FACILITY: Moore F.H. P.A. 125 2nd St. Denton, Md. 21629			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumococcal Meningitis	6 days
DUE TO (OR AS A CONSEQUENCE OF):	b. Chronic Lymphocytic Leukemia	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c.	
DUE TO (OR AS A CONSEQUENCE OF):	d. Pneumococcal Pneumonia	8 days

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Ludwig J. Eglseder III MD	md D 31466	▶ 12/4/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ludwig J. Eglseder III MD RT 3 Box 106 Easton md 21601

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 7 '89	Gina Davidson-Randall

OHMH-16 Rev 1/89

89 37727

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Pearl O. Quillen Usilton				2. DATE OF DEATH (Month, Day, Year): 12/11/89	3. TIME OF DEATH: 2:00A M
4. SOCIAL SECURITY NUMBER: 212-12-3409	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08/10/22	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Rt. 3, Box 48			9b. CITY, TOWN OR LOCATION OF DEATH: Federalsburg		9c. COUNTY OF DEATH: Caroline
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Federalsburg			10d. INSIDE CITY LIMITS? ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 104 Federal Manor Apartments			10f. ZIP CODE: 21632		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Librarian		16b. KIND OF BUSINESS/INDUSTRY: Education/Literature		
17. FATHER'S NAME (First, Middle, Last): Reverdy L. Quillen			18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca O. Skinner Quillen		
19a. INFORMANT'S NAME (Type/Print): Mrs. Mariam Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3, Box 48, Federalsburg, MD 21632			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Hill Crest Cemetery	20c. LOCATION — City or Town, State: Federalsburg, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Michael J. Eskow	22. NAME AND ADDRESS OF FACILITY: Framptom-Hawkins Funeral Home Federalsburg, MD				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cancer of lung — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
P. Gregg Rhodes MD	D14537	▶ 12/13/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): PGR P. GREGG RHODES, M.D. 503 DUTCHMAN'S LANE, EASTON, MD 21601

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 21 '89	Jacqueline Davidson-Randall

OHMH-15 Rev 1/89

89 37728

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Tracy	Lynn	Viar	12 26 89	1:20P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
236-23-7662	1 ☐ M 2 ☒ F	22 YRS.			6-26-67	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Washington County Hospital	Hagerstown	Washington

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Washington	Hagerstown	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
208 - 210 Brookside Terrace	21740	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12 years		Hairdresser	Hair

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
William C. Viar	Judy Lee Haines

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Judy L. Haines	230 Summit Avenue Hagerstown, Maryland 21740

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Greenlawn Memorial Park	Williamsport, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Gerald N. Minnich	Gerald N. Minnich Funeral Home 305 N. Potomac Street Hagerstown, Maryland

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Strangulation	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☒ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	12-20-89	A M	1 ☐ YES 2 ☒ NO	Subject strangled

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
Unknown	Unknown

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 12-28-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

James A. Kaplan, M.D.-Assistant 111 Penn ST., Baltimore, MD 21201

31. DATE RECD (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 02 '90	Judith Davidson-Randall

OHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37729

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)					2. DATE OF DEATH Month / Day / Year		3. TIME OF DEATH
Gladys C. WALKER					12 24 89		11:10 M
4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
212-12-3352	1 ☐ M 2 ☒ F	72 YRS.			11-12-1917		North Carolina
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH		
PENINSULA GENERAL HOSPITAL		SALISBURY, MARYLAND			WICOMICO		
RESIDENCE OF DECEDENT							
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?		
Maryland	Wicomico	Salisbury			1 ☒ YES 2 ☐ NO		
10e. STREET AND NUMBER		10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?		
520 Winder St. Apt. 45		21801			U.S.A.		
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. RACE — American Indian, Black, White, etc.		
1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:			Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12): 12	College (1-4 or 5+):	House Wife			None		
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)		
Alfred Watford					Carrie Hoggard		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Ceola Walker Coles		814 Ivy League Lane Rockville, Md. 20860					
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. LOCATION — City or Town, State		
1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		Green Acres			Salisbury, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY					
▶ Gladys B. Stewart		Clinton F. Stewart West Rd. Salis. 21801 Md					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. cardio respiratory arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. CHF
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☑ NO	HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
W B Horner MD	D13053	▶ 12/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
W. Benjamin Horner 100 Power Street Salisbury, MD 21801

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 28 '89	

3

DHMH-15 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37730

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES ORVILE WILLIS			2. DATE OF DEATH: MONTH 12 DAY 22 YEAR 1989	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 163-10-9974	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 12- 24- 1910	8. BIRTHPLACE (State or Foreign Country): PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number): MANOKIN MANOR		9b. CITY, TOWN OR LOCATION OF DEATH: PRINCESS ANNE		9c. COUNTY OF DEATH: SOMERSET
RESIDENCE OF DECEDENT				
10a. STATE: VIRGINIA	10b. COUNTY: ACCOMACK	10c. CITY, TOWN OR LOCATION: ACCOMAC		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: RFD		10f. ZIP CODE: 23301		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 11 YEARS; College (1-4 or 5+): ---	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): EXCEUTIVE	16b. KIND OF BUSINESS/INDUSTRY: PACKING MACHINERY COMPANY		
17. FATHER'S NAME (First, Middle, Last): FRANK ---- WILLIS		18. MOTHER'S NAME (First, Middle, Maiden Surname): ROSA --- GLINER		
19a. INFORMANT'S NAME (Type/Print): LYNNE W. PURVIS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): BOX 58, ACCOMAC, VA 23301		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify) 12/26/89	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): SALISBURY CREMATORY	20c. LOCATION — City or Town, State: SALISBURY, MD 21801		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ John M. Holloway		22. NAME AND ADDRESS OF FACILITY: HOLLOWAY FUNERAL HOME, PA 501 SNOW HILL RD, SALISBURY, MD 21801		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOPULMONARY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. ASCVD	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Dennis J Chodnicki	D20912	▶ 12/22/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 '89	Julia Davidson-Rendon

4

DHMH-18 Rev 1/89

89 37731

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Charles Columbus WILLIAMS
2. DATE OF DEATH (Month, Day, Year): Dec. 21, 1989
3. TIME OF DEATH:
4. SOCIAL SECURITY NUMBER: 705-07-7628
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 83 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): Sept. 19, 1906
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): 5506 Woodville Rd.
9b. CITY, TOWN OR LOCATION OF DEATH: Mt. Airy
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Mt. Airy
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 5506 Woodville Rd.
10f. ZIP CODE: 21771
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Trackman
16b. KIND OF BUSINESS/INDUSTRY: Railroad
17. FATHER'S NAME (First, Middle, Last): Columbus Williams
18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret unknown
19a. INFORMANT'S NAME (Type/Print): Spence Williams
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5506 Woodville Rd., Mt. Airy, Md. 21771
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Dorsey U.M. Church Cemetery
20c. LOCATION — City or Town, State: New London, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth
22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Heart Failure	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Congested heartfailure	2yrs
c. DUE TO (OR AS A CONSEQUENCE OF):	Hypertension	10yrs
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Dyspsia

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Morris A Wilkinson MD
29c. LICENSE NUMBER: D-20279
29d. DATE SIGNED (Month, Day, Year) ▶ Dec. 21, 1989
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Morris A. Wilkinson, M.D. 700 N. Market St., Frederick, Md. 21701
31. DATE FILED (Month, Day, Year): DEC 26 1989
32. REGISTRAR'S SIGNATURE: Jitha Davidson-Randall

OHMN-18 Rev 1/89

89 37732

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): John Edward Walters		2. DATE OF DEATH: MONTH 12 DAY 20 YEAR 89	3. TIME OF DEATH: 1720 P M
4. SOCIAL SECURITY NUMBER: 214-42-1000	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 45 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Mar. 31 1944
8. BIRTHPLACE (State or Foreign Country): MD.			
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT			
10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: N-104 Waverly Drive	10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Laborer	16b. KIND OF BUSINESS/INDUSTRY: Sanitation Dept.	
17. FATHER'S NAME (First, Middle, Last): Robert Leroy Walters	16. MOTHER'S NAME (First, Middle, Maiden Surname): Betty Jane Dinterman		
19a. INFORMANT'S NAME (Type/Print): Carol S. Walters	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): N-104 Waverly Dr., Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union Chapel Cemetery	20c. LOCATION — City or Town, State: Libertytown, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer	22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest	Minutes
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Advanced Small Cell Carcinoma of Lung	Months
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 9 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D35152	29d. DATE SIGNED (Month, Day, Year) ▶ 12/21/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. L. Krenik, 100 S. Center St, Thurmont MD 21788		
31. DATE FILED (Month, Day, Year): DEC 22 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

ITEMS:10a thru 10f per FH G-660
2-21-90 cm

89 37733

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLIFFORD A. WILLIAMSON		2. DATE OF DEATH (Month, Day, Year): December 20, 1989	3. TIME OF DEATH: 10:45 p M
4. SOCIAL SECURITY NUMBER: 484-30-5005	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-17-1931
8. BIRTHPLACE (State or Foreign Country): Minnesota			
9a. FACILITY NAME (If not institution, give street and number): Brooklawn Apts.	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: ~~Maryland~~ FLORDIA	10b. COUNTY: ~~Frederick~~ POLK Co.	10c. CITY, TOWN OR LOCATION: ~~Frederick~~ WINTER HAVEN	10d. INSIDE CITY LIMITS? ~~1 [X] YES~~ 2 [X] NO
10e. STREET AND NUMBER: ~~1001 Carroll Parkway~~ 34 BERNA CIRCLE	10f. ZIP CODE: ~~21701~~ 33884	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Peacetime	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Distribution Services	16b. KIND OF BUSINESS/INDUSTRY: Royalty Dist. Services, Inc.	
17. FATHER'S NAME (First, Middle, Last): James R. Williamson	18. MOTHER'S NAME (First, Middle, Maiden Surname): Claire Florence Hodge		
19a. INFORMANT'S NAME (Type/Print): Mark P. Williamson	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 115 Lauren Court Frederick, Md. 21701		
20a. METHOD OF DISPOSITION: ~~X~~ 1 [X] Burial 2 [ ] Cremation 3 [X] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mary Rest Cemetery	20c. LOCATION — City or Town, State: Mahwah, New Jersey	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr.	22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 N. Market St. Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Astrocytoma	18 mo
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D29675	29d. DATE SIGNED (Month, Day, Year): ▶ December 21, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ralph Boccia, M.D. 14808 Physicians Lane Suite 212 Rockville, Md.

31. DATE FILED (Month, Day, Year): DEC 21 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

89 37734

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dorothy S. Waters / DOROTHY S WATERS

2. DATE OF DEATH (Month, Day, Year): 11-30-89

3. TIME OF DEATH: 0333 M

4. SOCIAL SECURITY NUMBER: 578-80-2293 / 578-80-2293

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7. DATE OF BIRTH (Month, Day, Year): 06-19-1908

8. BIRTHPLACE (State or Foreign Country): Maryland

9a. FACILITY NAME (If not institution, give street and number): Carroll County General Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Westminster

9c. COUNTY OF DEATH: Carroll

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Montgomery

10c. CITY, TOWN OR LOCATION: Bethesda

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: 5315 Tuscarawas Road

10f. ZIP CODE: 20816

10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): — College (1-4 or 5+): 2

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Registered Nurse

16b. KIND OF BUSINESS/INDUSTRY: Hospital

17. FATHER'S NAME (First, Middle, Last): John Homer Reams

18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Borden

19a. INFORMANT'S NAME (Type/Print): William R. Waters, Jr.

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5016 Mount Zion Rd., Frederick, Maryland 21701

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory

20c. LOCATION — City or Town, State: Smithsburg, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ruth Lynn Roberson M00706

22. NAME AND ADDRESS OF FACILITY: Keeney & Basford P.A., 106 East Church St. Frederick, Maryland, 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Ventricular fibrillation — Instant

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — **28b. TIME OF INJURY** M — **28c. INJURY AT WORK?** 1 ☐ YES 2 ☐ NO — **28d. DESCRIBE HOW INJURY OCCURED**

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chitrachedy Nagarna

29c. LICENSE NUMBER: D18200

29d. DATE SIGNED (Month, Day, Year): ▶ 11-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHITRACHEDY N AGARWAL 700-A Poole Rd Westminster MD 21157

31. DATE FILED (Month, Day, Year): DEC 01 1989

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

4

Unknown #89-244

89 37735

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
~~MERA~~	~~WHISMAN~~ Mera	Lynn WHISMAN	12 / 21 / 89	3:30 A M

4. SOCIAL SECURITY NUMBER	5. SEX	5. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-90-1544	1 ☐ M 2 ☒ ~~F~~	23 YRS.			June 30, 1966	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
I270 near Rt. 85	Frederick	Frederick

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Frederick	Adamstown	1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2516 Park Mills Road	21710	U.S.A.

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☒ NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Waitress	Restaurant

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Wayne Whisman	Cathy Lenhart

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Cathy L. Thompson	1205 Wilson Place, Frederick, MAryland 21701

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☒ ~~Cremation~~ 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Smithsburg Crematory	Smithsburg, Maryland

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Keith Lynn Roberson M00706	Keeney & Basford Funeral Home 106 East Church Street, Frederick,MD 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries, smoke and soot inhalation	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. and thermal injuries DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☒ YES 2 ☐ NO	1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☒ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) scene

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☐ Natural 2 ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	12-21-89	M	1 ☐ YES 2 ☒ ~~NO~~	Driver in pickup truck/tractor trailor collision

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
road	I270 near Rt. 85, Frederick Co.

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 12-21-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

James A. Kaplan, M.D. 111 Penn Street Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 26 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37736

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARGARET WELSH Margaret C. Welsh
2. DATE OF DEATH (Month, Day, Year): 12/26/89
3. TIME OF DEATH: 6:15 PM
4. SOCIAL SECURITY NUMBER: 217-36-6249
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 76 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 3-14-13
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Brooke Grove Nursing Home
9b. CITY, TOWN OR LOCATION OF DEATH: Olney
9c. COUNTY OF DEATH: Montgomery

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Montgomery
10c. CITY, TOWN OR LOCATION: Damascus
10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 27609 Ridge Road
10f. ZIP CODE: 20872
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife
16b. KIND OF BUSINESS/INDUSTRY: Own home
17. FATHER'S NAME (First, Middle, Last): L. Edward Bowman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Jane Jones
19a. INFORMANT'S NAME (Type/Print): Shirley A. Cole
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 11517 Johns Hopkins Rd., Clarksville, Md. 21029
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Montgomery U.M. Cemetery
20c. LOCATION — City or Town, State: Damascus, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth
22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Valvular Heart disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☑ Nursing Home 8 ☐ Residence 8 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending Investigation 8 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: John Lodmell MD
29c. LICENSE NUMBER: D0S809.
29d. DATE SIGNED (Month, Day, Year): ▶ 12-26-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): JOHN G. LODMELL MD. 2901 OLNEY RD. OLNEY MD 20832
31. DATE FILED (Month, Day, Year): DEC 28 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37737

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ERMA E. WAGNER (Erma E. WAGNER)				2. DATE OF DEATH: MONTH Dec. DAY 6 YEAR '89	3. TIME OF DEATH: 10:00 P. M
4. SOCIAL SECURITY NUMBER: 579-22-0279	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 7, 1895	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Summit Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH: Catonsville		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Mt. Airy			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 647 Lake View Dr.		10f. ZIP CODE: 21771		10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puarto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Office Supervisor		16b. KIND OF BUSINESS/INDUSTRY: U.S. Government	
17. FATHER'S NAME (First, Middle, Last): David W. Smith		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice V. Day			
19a. INFORMANT'S NAME (Type/Print): Arline W. Snead		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6121 Burnt Oak Rd., Catonsville, Md. 21228			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Pine Grove Cemetery		20c. LOCATION — City or Town, State: Mt. Airy, Md. 21771	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth		22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Stroke	2 days
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Atherosclerotic Vascular Disease	10 yrs.
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Diabetes Mellitus
Chronic Congestive Heart Failure

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
J. Nelson McKay M.D.	DO 6895	▶ Dec 6, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J. NELSON McKAY M.D. 413 COMMONWEALTH AVE. Balto, MD-21228.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 11 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37738

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Erman WARDENFELT			2. DATE OF DEATH (Month, Day, Year): December 3 1989	3. TIME OF DEATH: 3:30 A M
4. SOCIAL SECURITY NUMBER: 214-16-0644	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 10-25-1916	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital, Baltimore		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore		10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1927 Kelmore Road		10f. ZIP CODE: 21222		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist		16b. KIND OF BUSINESS/INDUSTRY: Key Highway Shipyard
17. FATHER'S NAME (First, Middle, Last): Harmon Wardenfelt		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Wardenfelt		
19a. INFORMANT'S NAME (Type/Print): Charlotte Wardenfelt		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1927 Kelmore Road, Baltimore, MD 21222		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Glade Cemetery		20c. LOCATION — City or Town, State: Walkersville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brenda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Lung Carcinoma
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M. Wolff, MD	N/A	▶ 12-3-1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Marcos Wolff M.D. 9000 Franklin Square Drive, Baltimore Md. 21237

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 04 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37739

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hilda Ruth Warner Williar
2. DATE OF DEATH (Month, Day, Year): 12 9 89
3. TIME OF DEATH: 2328 P M
4. SOCIAL SECURITY NUMBER: 215-03-0393-B
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): 77 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 1/22/12
8. BIRTHPLACE (State or Foreign Country): MD - USA
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Frederick
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 7612 A Devilbiss Bridge Road
10f. ZIP CODE: 21701
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Charles W. Warner
18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Cantwell Warner
19a. INFORMANT'S NAME (Type/Print): Rosemarie Powell
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7612 A Devilbiss Bridge Rd., Frederick, Md
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens
20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ G. Douglas Stauffer
22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA
P.O. Box 1819, Frederick, MD 21701

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arreat, shock, or heart feilure. List only one ceuse on aach lina.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. TERMINAL METASTATIC ENDOMETRIAL CARCINOMA	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Arthur L. Rawlins M.D.
29c. LICENSE NUMBER: D-18191
29d. DATE SIGNED (Month, Day, Year): ▶ 12/15/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ARTHUR G. MANASSAS, M.D. 187 Thos Johnson Dr. Frederick, MD, 21701

31. DATE FILED (Month, Day, Year): DEC 11 1989
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37740

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in obtaining burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EVERS FRANKLIN WEDDLE			2. DATE OF DEATH: MONTH 11 DAY 30 YEAR 89	3. TIME OF DEATH: 1520 PM
4. SOCIAL SECURITY NUMBER: 215-14-2209	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 81 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7/24/08	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Thurmont		10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 111 East Main Street		10f. ZIP CODE: 21788		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Truck driver		16b. KIND OF BUSINESS/INDUSTRY: Trucking/Transfer	
17. FATHER'S NAME (First, Middle, Last): Evers Freed Weddle		18. MOTHER'S NAME (First, Middle, Maiden Surname): Bessie V. Unger		
19a. INFORMANT'S NAME (Type/Print): Betty Lou Toms		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 111 East Main St. Thurmont, MD 21788		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): United Brethren		20c. LOCATION — City or Town, State: Thurmont, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr		22. NAME AND ADDRESS OF FACILITY: Robert E. Dailey & Son Funeral Homes, PA 615 E. Main St. Thurmont, MD 21788		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Arrest	Minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	Days
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Renal Insufficiency

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
MD	D35152	▶ 11/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.K. Krantz, MD 100 S. Center St. Thurmont, MD 21788

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 01 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37741

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): CLIFFORD . WILLIAM WILLARD			2. DATE OF DEATH (Month / Day / Year): 12 / 10 / 89	3. TIME OF DEATH: 1949 PM
4. SOCIAL SECURITY NUMBER: 217-12-2100	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 66 YRS. (If under 1 year: Months / Days; If under 24 hrs.: Hours / Min.)	7. DATE OF BIRTH (Month, Day, Year): MAY 6, 1923	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): WASHINGTON COUNTY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: HAGERSTOWN		9c. COUNTY OF DEATH: WASHINGTON

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY: FREDERICK	10c. CITY, TOWN OR LOCATION: FOXVILLE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 14770 HERMAN HAUVER RD.		10f. ZIP CODE: 21780	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOOR HANGER	16b. KIND OF BUSINESS/INDUSTRY: JAMISON DOOR COMPANY	
17. FATHER'S NAME (First, Middle, Last): CLIFFORD DONALD WILLARD		18. MOTHER'S NAME (First, Middle, Maiden Surname): PEARL VICTORIA BROWN	
19a. INFORMANT'S NAME (Type/Print): RANDALL E. WILLARD (SON)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13 W. MAIN ST., THURMONT, MD. 21788	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GARFIELD CEMETERY	20c. LOCATION — City or Town, State: GARFIELD, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON, P.A. 615 E. MAIN ST., THURMONT, MD. 21788	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac Arrest	immediate
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Coronary Artery Disease	10 yrs.
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Charles E. Hess MD	29c. LICENSE NUMBER: DO 4975	29d. DATE SIGNED (Month, Day, Year): ▶ 12-11-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): DEC 13 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37742

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ALICE VIRGINIA WICKLESS				2. DATE OF DEATH (Month, Day, Year): December 8, 1989	3. TIME OF DEATH: 4:30 A M
4. SOCIAL SECURITY NUMBER: 218-40-3472	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 16, 1913	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): 503 Culler Avenue		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick,		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 503 Culler Avenue		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: X		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4 years	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Retired Teacher		16b. KIND OF BUSINESS/INDUSTRY: Teaching	
17. FATHER'S NAME (First, Middle, Last): William T. Saunders		18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Winifred Cain			
19a. INFORMANT'S NAME (Type/Print): Mrs. JoAnne Gardner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10802 Chestnut Grove Circle Frederick, Md. 21701			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mount Olivet Cemetery		20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr.		22. NAME AND ADDRESS OF FACILITY: ROBERT E. DAILEY & SON, P. A. 1201 N. Market St., Fred. Md. 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Colon Cancer	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Joseph Ashwal MD	D26609	12/8/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Joseph Ashwal, MD 56 Thomas Johnson Drive, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 12 1989	Julia Davidson-Randall

DHMH-16 Rev 1/89

6

89 37743

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WATERS Waters Josephine			2. DATE OF DEATH (Month, Day, Year): Jan 9 1990	3. TIME OF DEATH: M
4. SOCIAL SECURITY NUMBER: 154-22-2489	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 98 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Sept 27, 1891
8. BIRTHPLACE (State or Foreign Country): Md.				
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge		9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 625 High St. Cambridge, Md.	10f. ZIP CODE: 21613	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Thomas H. Miles	18. MOTHER'S NAME (First, Middle, Maiden Surname): Watitia Miles	
19a. INFORMANT'S NAME (Type/Print): Remonia Jones	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 802 Bradley Ave Camb. Md. 21613	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Waugh Cem	20c. LOCATION — City or Town, State: Cambridge, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Danielle C. Henry	22. NAME AND ADDRESS OF FACILITY: Henry Funeral Home	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure	Months
	DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Howard E. Ayliffe, M.D.	31018	▶ 1/11/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH ITEM 27) (Type, Print): 408 Byrn Street Cambridge Maryland 21613

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 16 '90	Lisha Davidson-Randall

DHMH-16 Rev 1/89

89 37744

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Beatrice Virginia Waters			2. DATE OF DEATH: MONTH 12 DAY 29 YEAR 89	3. TIME OF DEATH: 5:10 P M
4. SOCIAL SECURITY NUMBER: 214-09-0612	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 84 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10-22-05	8. BIRTHPLACE (State or Foreign Country): Virginia
9a. FACILITY NAME (If not institution, give street and number): Reeders Memorial Home		9b. CITY, TOWN OR LOCATION OF DEATH: Boonsboro	9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Boonsboro	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 141 S. Main Street		10f. ZIP CODE: 21713	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): 8th grade; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress	16b. KIND OF BUSINESS/INDUSTRY: Department Store	
17. FATHER'S NAME (First, Middle, Last): Robert L. Waters		18. MOTHER'S NAME (First, Middle, Maiden Surname): Annie R. YOunkins	
19a. INFORMANT'S NAME (Type/Print): Gladys L. Tritapoe		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1638 Rohrersville Rd. Knoxville, Maryland 21758	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Old Brownsville Cemetery	20c. LOCATION — City or Town, State: Brownsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Douglas A. Fiery Douglas A. Fiery	22. NAME AND ADDRESS OF FACILITY: Bast Funeral Home	7606 Boonsboro Pike Boonsboro, Maryland	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. probable thrombotic cerebrovascular accident	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: end-stage organic brain syndrome

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: R Guedenet	29c. LICENSE NUMBER: D32518	29d. DATE SIGNED (Month, Day, Year): ▶ 12-29-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DR. GUEDENET, 100 GEETING LANE KEEDYSVILLE, MD. 21756

31. DATE FILED (Month, Day, Year): JAN 02 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed/filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37745

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page ... be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Albert Westley Woods			2. DATE OF DEATH (Month / Day / Year): 12 / 17 / 89	3. TIME OF DEATH: 10 00 A M
4. SOCIAL SECURITY NUMBER: 219-36-8741	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 84 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 7-18, 1905	8. BIRTHPLACE (State or Foreign Country): Columbia, Miss
9a. FACILITY NAME (If not institution, give street and number): Rt. 1 Box F58		9b. CITY, TOWN OR LOCATION OF DEATH: Greensboro		9c. COUNTY OF DEATH: Caroline

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Greensboro	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rt. 1 Box F58		10f. ZIP CODE: 21639	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 4+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher	16b. KIND OF BUSINESS/INDUSTRY: University	
17. FATHER'S NAME (First, Middle, Last): (unknown) Woods		18. MOTHER'S NAME (First, Middle, Maiden Surname): Marcie Sapp Woods	
19a. INFORMANT'S NAME (Type/Print): Edith Marie Woods		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 1 Box F58 Greensboro, MD 21639	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Salisbury Crematory	20c. LOCATION — City or Town, State: Salisbury, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY: Fleegle-Helfenbein Fn Hm P.O. Box 160 Greensboro, MD 21639	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Overwhelming Sepsis

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. Pneumonia

DUE TO (OR AS A CONSEQUENCE OF):

c. Chronic Bronchitis

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD, Multinfarct Dementia

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Rob Lappin MD	29c. LICENSE NUMBER: D33294	29d. DATE SIGNED (Month, Day, Year) ▶ 12/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Rob Lappin MD PO Box 122 Goldsboro, Md. 21636		
31. DATE FILED (Month, Day, Year): DEC 18 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

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89 37746

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eleanor Virginia ZIMMERMAN			2. DATE OF DEATH (Month, Day, Year): December 21, 1989	3. TIME OF DEATH: 1:10 p M
4. SOCIAL SECURITY NUMBER: 214-10-4327	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): March 27, 1900	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Citizens Nursing Home of Fred. Co.		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 405 Sherman Avenue		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 5+):		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Seamstress		16b. KIND OF BUSINESS/INDUSTRY: Seamstress - self employed
17. FATHER'S NAME (First, Middle, Last): Thomas Walter Clevenger		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Lee Hardesty		
19a. INFORMANT'S NAME (Type/Print): Mrs. Eleanore Stine		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 624 East Main St., Thurmont, Md. 21788		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery		20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward C. Basford M00021		22. NAME AND ADDRESS OF FACILITY: Keeney and Basford Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiac arrhymia	2 years
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Arteriosclerotic cardiovascular disease	5 years
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Osteoarthritis

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: LeRoy T. Davis, M.D.	29c. LICENSE NUMBER: D01902	29d. DATE SIGNED (Month, Day, Year): 12/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. LeRoy T. Davis, M.D., 801 Toll House Ave., Frederick, Md. 21701		
31. DATE FILED (Month, Day, Year): DEC 22 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-18 Rev 1/89

89 37747

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): MARJORIE ZIRKLE Marjorie M. ZIRKLE			2. DATE OF DEATH (Month, Day, Year): 11/4/89	3. TIME OF DEATH: 4:55 PM. M
4. SOCIAL SECURITY NUMBER: 065-26-6778	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 61 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-4-28	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Joseph Richey House Inc.		9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore		9c. COUNTY OF DEATH: City
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: Howard	10c. CITY, TOWN OR LOCATION: Mt. Airy		10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 1705 Shaffersville Rd.		10f. ZIP CODE: 21771		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teachers Aide		16b. KIND OF BUSINESS/INDUSTRY: County Schools	
17. FATNER'S NAME (First, Middle, Last): Francis Mortimer Conklin			18. MOTNER'S NAME (First, Middle, Maiden Surname): Marjorie Marion Howell	
19a. INFORMANT'S NAME (Type/Print): Janice Zirkle		19b. MAILINO ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5716 Thunder Hill Rd., Columbia, Md. 21045		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Poplar Springs Cemetery	20c. LOCATION — City or Town, State: Poplar Springs, Md.	
21. SIONATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth		22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not anter the mode of dying, such as cerdiec or reapiratory arreat, shock, or heart feilure. List only one cause on each line.

		Approximata Intarval Batween Onset and Daath
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Metastatic carcinoma	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. Renal cell carcinoma	

PART II. Othar significant conditions contributing to death but not resulting in tha underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATN: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEOICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIONED (Month, Day, Year)
Alice B. Heisler M.D.	D05055	▶ 11-4-89

30. NAME ANO AOORESS OF PERSON WNO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print): Alice B. Heisler M.D. - 630 W. Fayette St. Baltimore, Md. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
NOV 06 1989	Julia Davidson-Randall

DNMH-16 Rev 1/89

89 37748

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William Thomas Zerr		2. DATE OF DEATH (Month, Day, Year): 12 30 1989	3. TIME OF DEATH: 11:30 AM
4. SOCIAL SECURITY NUMBER: 212-10-3580	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 1-18-1895
8. BIRTHPLACE (State or Foreign Country): Kentucky			
9a. FACILITY NAME (If not institution, give street and number): Box 4411 Danwood Dr.	9b. CITY, TOWN OR LOCATION OF DEATH: Salisbury	9c. COUNTY OF DEATH: Wicomico	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Salisbury	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Box 4411 Danwood Dr.	10f. ZIP CODE: 21803	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WW1 Army	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 6	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Attorney at Law	16b. KIND OF BUSINESS/INDUSTRY: Maryland Casualty Co.
17. FATHER'S NAME (First, Middle, Last): Michael V. Zerr		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rebecca Mc Kinney	
19a. INFORMANT'S NAME (Type/Print): William Zerr		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Box 4411 Danwood Dr. Salisbury, MD 21803	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cape Henlopen Crematory	20c. LOCATION — City or Town, State: Frankford, Del.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ B. Kent Phypps		22. NAME AND ADDRESS OF FACILITY: Bounds Funeral Home Salisbury, MD 2180	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest — min

DUE TO (OR AS A CONSEQUENCE OF):
b. Coronary Artery Disease

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Cerebral Infarcts, multiple

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Hilda O'Houlihan MD	29c. LICENSE NUMBER: D 04884	29d. DATE SIGNED (Month, Day, Year): ▶ 12/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Hilda Houlihan, M.D. Camden Ave. Salisbury, Maryland 21801

31. DATE FILED (Month, Day, Year): JAN 2 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson Hendrickson

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DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37749

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY BOY (B) BRINKLEY
2. DATE OF DEATH: MONTH DECEMBER DAY 8, YEAR 1989
3. TIME OF DEATH: 8:35 p M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS 4 MIN. 4
7. DATE OF BIRTH (Month, Day, Year): 12/8/89
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND
10b. COUNTY: MARYLAND
10c. CITY, TOWN OR LOCATION: BALTIMORE MARYLAND
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 3213 EMLEY AVE
10f. ZIP CODE: 21213
10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NEWBORN
16b. KIND OF BUSINESS/INDUSTRY:
17. FATHER'S NAME (First, Middle, Last): TYRONE CHANEY
18. MOTHER'S NAME (First, Middle, Maiden Surname): VERNETTA BRINKLEY
19a. INFORMANT'S NAME (Type/Print): VERNETTA BLANKLEY
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3213 EMLEY AVE BALTIMORE, Md. 21213
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): THE JOHNS HOPKINS HOSPITAL
20c. LOCATION — City or Town, State: BALTIMORE, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: 600 N. WOLFE STREET. #21205

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mods of dying, such as cardiac or respiretory srrest, shock, or heart feilure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. PREMATURITY - 20 3/7 WEEKS GESTATION	2 HOURS
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: NONE KNOWN —

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED: N/A
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A

29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Michelle Gresham Dundore
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 12/8/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHELLE GRESHAM DUNDORE — THE JOHNS HOPKINS HOSPITAL 600 N. WOLFE STREET BALTIMORE, MD 21205
31. DATE FILED (Month, Day, Year):
32. REGISTRAR'S SIGNATURE: FEB 21 1990 Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37750

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Moses Della Pomevor Cobblah					2. DATE OF DEATH: MONTH 12 DAY 4 YEAR 89	3. TIME OF DEATH: 8:21PM M
4. SOCIAL SECURITY NUMBER: 212-17-1200	5. SEX: 1 XX M 2 ☐ F	6. AGE (in yrs. last birthday): 37 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): September 25, 1952	8. BIRTHPLACE (State or Foreign Country): Kedzi, Ghana
9a. FACILITY NAME (If not institution, give street and number): 3558 Dean Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Hyattsville		9c. COUNTY OF DEATH: Prince Georges Co.	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Hyattsville			10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO	
10e. STREET AND NUMBER: 3558 Dean Drive; Apt. B		10f. ZIP CODE: 20783			10g. CITIZEN OF WHAT COUNTRY? Ghana, Africa	
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 XX NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 5 +):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Accountant	16b. KIND OF BUSINESS/INDUSTRY: Private Industry				
17. FATHER'S NAME (First, Middle, Last): Anani Pomevor	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mercy Alormasor					
19a. INFORMANT'S NAME (Type/Print): William K. Ayenson (cousin)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 9208 Honey Creeper Court, Burke, Virginia 22015					
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Rock Creek Cemetery	20c. LOCATION — City or Town, State: Washington, D. C.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: John Luther Latney Jr	22. NAME AND ADDRESS OF FACILITY: Latney's Funeral Home 3831 Georgia Avenue, N.W.; Wash. D.C. 20011					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Intracerebral hemorrhage	
	DUE TO (OR AS A CONSEQUENCE OF): Hypertensive cardiovascular disease	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XX YES 2 ☐ NO	XX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
XX YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 XX Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
XX 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	OCME	▶ 12-5-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Frank Peretti, MD 111 Penn Street, Baltimore, MD 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 25 '90	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37751

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Harold Henry Curd		2. DATE OF DEATH: MONTH DEC DAY 30 YEAR 1989	3. TIME OF DEATH: 7:02 P M
4. SOCIAL SECURITY NUMBER: 308-26-7992	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 59 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): DEC 19 1930
8. BIRTHPLACE (State or Foreign Country): Indiana			
9a. FACILITY NAME (If not institution, give street and number): National Naval Medical Center	9b. CITY, TOWN OR LOCATION OF DEATH: Bethesda	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: Delaware	10b. COUNTY: Kent	10c. CITY, TOWN OR LOCATION: Dover	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 439 Collins Drive	10f. ZIP CODE: 19901	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS: 1 ☐ Never Married 2 X Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 ☐ NO IF YES, GIVE WAR OR DATES: 02/48 to 02/68	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+): 3	15e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Computer Operator	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Elijah (Unknown) Curd	18. MOTHER'S NAME (First, Middle, Maiden Surname): Roxie (Unknown) Wigley		
19a. INFORMANT'S NAME (Type/Print): Willa Curd	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 439 Collins Dr., Dover, DE 19901		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Delaware Veterans Cem.	20c. LOCATION — City or Town, State: Bear Delaware 19701	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Edward G Minus	22. NAME AND ADDRESS OF FACILITY: Minus Funeral Home 222 N. Queen Street Dover Delaware		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cerebral Vascular Accident
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 X NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: X 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Dale E Braun
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): 31 Dec 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dale E. Braun LCDR,MC,USN National Naval Medical Center Bethesda, MD 20814

31. DATE FILED (Month, Day, Year): JAN 3 '90
32. REGISTRAR'S SIGNATURE: Githa Davidson-Randall

DHMH-16 Rev 1/89

Unknown #89-251

89 37752

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
ROBERT	JUNIOR	DEANER	12 / 29 / 89	1:20 P M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	1 [X] M 2 [ ] F	56 YRS.			10/23/1933	CLEVELAND, OHIO

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Woods of Pulaski Highway		Baltimore

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND		BALTIMORE, MARYLAND	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
JAMES HARRY DEANER	GLADYS THOMAS DEANER

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
JAMES HARRY DEANER	HOT SPRINGS, VA. 24445

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	WARM SPRINGS, CEMETERY	WARM SPRINGS, VA.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
	ESTEP BROTHERS FUNERAL SERVICE, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Exposure to cold and Arteriosclerotic	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. cardiovascular disease DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	1 [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [X] Other (Specify) scene

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	unknown	M	1 [ ] YES 2 [X] NO	Exposure to cold

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
woods	Woods of Pulaski Highway, Balto, Co.

29a. CERTIFIER (Check only one)

1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin	OCME	▶ 12-30-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Julia C. Goodin, M.D.-Assistant 111 Penn Street Baltimore, Md. 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
FEB 15 1990	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 4 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37753

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached from page 4 and used as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Geddie — JAMES HUBERT GEDDIE
2. DATE OF DEATH (Month, Day, Year): 12 27 89
3. TIME OF DEATH: 12:28 P M
4. SOCIAL SECURITY NUMBER: 577-40-5510
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7. DATE OF BIRTH (Month, Day, Year): 12/24/31
8. BIRTHPLACE (State or Foreign Country): North Carolina
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hosp Ctr.
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: District
10b. COUNTY: of Columbia
10c. CITY, TOWN OR LOCATION: Washington
10d. INSIDE CITY LIMITS?: 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1432 Saratoga Avenue, N.E.; Apt. 4
10f. ZIP CODE: 20018
10g. CITIZEN OF WHAT COUNTRY?: United States
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES?: 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc.: Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): unknown; College (1-4 or 6+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Construction Worker
16b. KIND OF BUSINESS/INDUSTRY: Construction
17. FATHER'S NAME (First, Middle, Last): Sinester Geddie Sr.
18. MOTNER'S NAME (First, Middle, Maiden Surname): Frances McCloud
19a. INFORMANT'S NAME (Type/Print): Sinester Geddie, Jr. (brother)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3101 Georgia Avenue, N.W.; Washington, D.C. 20010
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): National Harmony Memorial Park
20c. LOCATION — City or Town, State: Landover, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Carol Latney-Coleman
22. NAME AND ADDRESS OF FACILITY: Latney's Funeral Home, 3831 Georgia Avenue, N.W.; Wash. D.C. 20011

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio Pulmony Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. End Stage Renal Disease / Chronic Renal failure
DUE TO (OR AS A CONSEQUENCE OF):
c. Hyper Kalemia
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Hypertension
Diabetes Mellitus
Pulmonary Tuberculosis

24a. WAS AN AUTOPSY PERFORMED?: 1 [ ] YES 2 [X] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?: 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER?: 1 [X] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK?: 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one):
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Linda Whitby MD
29c. LICENSE NUMBER: D17162
29d. DATE SIGNED (Month, Day, Year): 1/2/27/09
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Linda Whitby MD 9552 CROIN Hwy Upper Marlboro, MD 20772
31. DATE FILED (Month, Day, Year): JAN 25 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

RA 31123

89 37754

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Hayes (Baby Boy Hayes)		2. DATE OF DEATH (Month, Day, Year): 12 20 89	3. TIME OF DEATH: 5:05 AM
4. SOCIAL SECURITY NUMBER: none	5. SEX: 1 X M 2 ☐ F	6. AGE (If less than 1 day, hours or minutes; if less than 1 year, days or months): YRS.	7. DATE OF BIRTH (Month, Day, Year): 12-20-89
8. BIRTHPLACE (State or Foreign Country): Md.			
9a. FACILITY NAME (If not institution, give street and number): Wash Adventist Hosp	9b. CITY, TOWN OR LOCATION OF DEATH: Takoma Park, Md	9c. COUNTY OF DEATH: Montgomery	
RESIDENCE OF DECEDENT			
10a. STATE: Md	10b. COUNTY: Mongomery	10c. CITY, TOWN OR LOCATION: Silver SPring	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 1105 Navahoe St.	10f. ZIP CODE: 20903	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): none; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none-infant	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): n/a	18. MOTHER'S NAME (First, Middle, Maiden Surname): Arletta Hayes		
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Asystole	} 1½ hr.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Non-Viable fetus	
	c. DUE TO (OR AS A CONSEQUENCE OF): Premature Birth (22-weeks Approximately)	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): NA	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Lawrence F. Cohen MD	29c. LICENSE NUMBER: D-17566	29d. DATE SIGNED (Month, Day, Year) ▶ 12/20/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Lawrence F. Cohen MD, 10313 Georgia Ave, #303, Silver Spring, Md		
31. DATE FILED (Month, Day, Year): 12/7	32. REGISTRAR'S SIGNATURE: FEB 21 1990 Julia Davidson-Randall	

DHMH-16 Rev 1/89

89 37755

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Dollie Jones Dollie Jones				2. DATE OF DEATH (Month, Day, Year): 12 29 89	3. TIME OF DEATH: 6:00 AM 6 A.M.
4. SOCIAL SECURITY NUMBER: 239-20-1678	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 89 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8-9-1900	8. BIRTHPLACE (State or Foreign Country): AUGUSTA, GA.
9a. FACILITY NAME (If not institution, give street and number): DORCHESTER GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: CAMBRIDGE		9c. COUNTY OF DEATH: DORCHESTER

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: WICOMICO	10c. CITY, TOWN OR LOCATION: DELMAR	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: RTE. 1 BOX 66A		10f. ZIP CODE: 21875	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 4th. GRADE; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): DOMESTIC	16b. KIND OF BUSINESS/INDUSTRY: HOUSEKEEPER	
17. FATHER'S NAME (First, Middle, Last): UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname): UNKNOWN	
19a. INFORMANT'S NAME (Type/Print): EVANGELINE DAVIS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): RTE.1, BOX 67, DELMAR, MD. 21875	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): STEPHEN FIELD	20c. LOCATION — City or Town, State: WETIPQUIN, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Loretta B. Jolley		22. NAME AND ADDRESS OF FACILITY: RTE.2, BOX 920, SALISBURY, MD. 21801 JOLLEY MEMORIAL CHAPEL	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Possible CVA

DUE TO (OR AS A CONSEQUENCE OF): Generalized Arteriosclerosis Possible CVA

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF): Generalized arteriosclerosis

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Dehydration, Organic B Syndrom

Dehydration Organic Brain Syndrome

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: E Tanman	29c. LICENSE NUMBER: D14349	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Eyup Tanman 15 Franklin Street, Cambridge, Maryland 21613

31. DATE FILED (Month, Day, Year): JAN 9 '90	32. REGISTRAR'S SIGNATURE: [redacted]

DHMH-18 Rev 1/89

89 37756

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1 - 13 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) LORRAINE LENARDSON Lorraine Lenardson					2. DATE OF DEATH MONTH 12 DAY 30 YEAR 89	3. TIME OF DEATH 6.04 A M
4. SOCIAL SECURITY NUMBER 216-74-4032	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) APRIL 27, 1911	8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA
9a. FACILITY NAME (If not institution, give street and number) DORCHESTER GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE			9c. COUNTY OF DEATH DORCHESTER
RESIDENCE OF DECEDENT						
10a. STATE MARYLAND	10b. COUNTY DORCHESTER		10c. CITY, TOWN OR LOCATION EAST NEW MARKET			10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER BEL AIRE ROAD			10f. ZIP CODE 21631			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11	College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY -
17. FATHER'S NAME (First, Middle, Last) FLOYD ROBINSON					18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN	
19a. INFORMANT'S NAME (Type/Print) DOUGLAS B. LENARDSON			19b. MAILIND ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RFD, BOX 135A, EAST NEW MARKET, MD 21631			
20a. METHOD OF DISPOSITION 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MD EASTERN SHORE VETERANS CEM.			20c. LOCATION — City or Town, State BEULAH, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leonard D. Zeller			22. NAME AND ADDRESS OF FACILITY ZELELR FUNERAL HOME EAST NEW MARKET, MD 21631			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cirrhosis of liver, marked.	Yrs,
DUE TO (OR AS A CONSEQUENCE OF):	Cirrhosis of liver marked	Yrs
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Alcoholism	Yrs Yrs.
c. DUE TO (OR AS A CONSEQUENCE OF):	Bronchopneumonia	hours.
d.	Bronchopneumonia	hours

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Pyelonephritis right kidney. Atherosclerosis
Pyelonephritis right kidney atherosclerosis of proximal portion of left internal carotid
of proximal portion of left internal carotid.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Hubert L. Fiery, M.D. Hubert L. Fiery MD	D22773	▶ 1/19/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 503 Byrn Street Cambridge, MD 21613
503 BYRN ST CAMB Md 21613

31. DATE FILED (Month, Day, Year)	32. REDISTRAR'S SIGNATURE
JAN 25 '90	Julia Davidson-Randall

DHMH-18 Rev 1/89

89 37757

Info. added per F.H.,orig. lost from M.E.'s off.2/8/90 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
LARRY	WAYNE	LEWIS	12-7-89	12:55PM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
222-56-2750	1 [X] M 2 [ ] F	25 YRS.			Jan. 22, 1964	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Union Hospital of Cecil County	Elkton	Cecil County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Delaware	New Castle	Newark	1 [ ] YES 2 [X] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
133 Edinburg Drive	19702	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
[X] 1 Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
12		Caretaker,maintenance	self employed

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
John C. Lewis	Shirley A. Sartin

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Shirley A. Lewis	Kirkwood, Delaware

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
[X] 1 Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	St. George's Cemetery	St. George's, De.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Robert Hutchison	212 N. Broad St. Hutchison Funeral Home, Middletown,DE 19709

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac arrhythmia with congestive heart failure

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
[X] 1 YES 2 [ ] NO	[X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
[X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [X] Outpatient 3 [X] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
[X] 1 Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
[X] 3 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Margarita Korell MD	OCME	▶ 2-6-90 REISSUED

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
MARGARITA A. KORELL,MD 111 Penn Street,Baltimore,MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
FEB 8 '90	Julia Davidson-Randall

DHMH-16 Rev 1/89

89 37758

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

10

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Almeda Virginia McCusker				2. DATE OF DEATH (Month, Day, Year): December 31, 1989	3. TIME OF DEATH: 10:05 A M
4. SOCIAL SECURITY NUMBER: 219-20-2415	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/15/1913	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Baltimore County General Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Randallstown		9c. COUNTY OF DEATH: Baltimore
RESIDENCE OF DECEDENT					
10a. STATE: Pa.	10b. COUNTY: Adams	10c. CITY, TOWN OR LOCATION: Hanover			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 636 3rd Street			10f. ZIP CODE: 17331		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): William McGowan			18. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Ebersole		
19a. INFORMANT'S NAME (Type/Print): William L. McCusker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 59 W.Chase Street Westminister, Md. 21157			
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St.Peters Catholic Cemetery		20c. LOCATION — City or Town, State: Hancock, Md. 21750	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]		22. NAME AND ADDRESS OF FACILITY: Grove FUneral Home 141 West Main Street Hancock, Md. 21750			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or reapiretory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. MYOCARDIAL INFARCT Acute	Hours.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic Obstructive Lung disease Yrs	Yrs.
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. AS Hypertensive disease	Years.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)			
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature]	D09068	▶ 1/6/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mokhtar Milaninia 1933 Va. Avenue Hagerstown, Maryland 21740

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 16 1990	[signature]

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 1 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89 37759

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY BOY ROSS			2. DATE OF DEATH (Month, Day, Year): OCTOBER 26, 1989	3. TIME OF DEATH: 3:18 A M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 1 / MIN. 17	7. DATE OF BIRTH (Month, Day, Year): 10/26/89	8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE
RESIDENCE OF DECEDENT				
10a. STATE: MARYLAND	10b. COUNTY: MSRYLAND		10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 24 MERCURY COURT			10f. ZIP CODE: 21234	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NEWBORN	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): MALCOLM D. ROSS			18. MOTHER'S NAME (First, Middle, Maiden Surname): RENEE D. DARGAN	
19a. INFORMANT'S NAME (Type/Print): RENEE D. ROSS			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 24 MERCURY COURT. BALTIMORE, Md. 21234	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): THE JOHNS HOPKINS HOSPITAL	20c. LOCATION — City or Town, State: BALTIMORE MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶			22. NAME AND ADDRESS OF FACILITY: 600 N. WOLFE STREET #21205	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ANOXIC ASYSTOLE	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. RESPIRATORY DISTRESS SYNDROME (SEVERE)	FROM BIRTH
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. PREMATURITY (NON-VIABLE FETUS)	FROM BIRTH
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Jeffrey J Stoddard MD Pediatric House Officer	A9566	▶ 10/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
JEFFREY J STODDARD DEPT OF PEDIATRICS JHH 601 N.WOLFE ST BALTO MD 21205

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE

DNMN-16 Rev 1/89

89 37760

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joseph T. Ryan			2. DATE OF DEATH MONTH 12 DAY 19 YEAR 89	3. TIME OF DEATH 2:05a M
4. SOCIAL SECURITY NUMBER: 097-24-0494	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 58 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 8-16-31	8. BIRTHPLACE (State or Foreign Country): NY, USA
9a. FACILITY NAME (If not institution, give street and number): Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Easton		9c. COUNTY OF DEATH: Talbot

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Caroline	10c. CITY, TOWN OR LOCATION: Marydel	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: Rd. 1 Box 105		10f. ZIP CODE: 21619	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Tug boat-cook	16b. KIND OF BUSINESS/INDUSTRY: boating
17. FATHER'S NAME (First, Middle, Last): James T. Ryan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Meade Ryan	
19a. INFORMANT'S NAME (Type/Print): Sarah Riley Ryan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rd. 1 Box 105, Marydel, MD 21619	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Greensboro Cemetery	20c. LOCATION — City or Town, State: Greensboro, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Stephen C Haugh		22. NAME AND ADDRESS OF FACILITY: P.O Box 160 Greensboro Md. Fleagle - Helfenbein FH	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive Heart Failure	0
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chronic obstructive pulmonary disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Arteriosclerosis

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	25. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D35284	29d. DATE SIGNED (Month, Day, Year) ▶ 12/22/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): ANDREA ALLEN, PO BOX 122 GOLDSBORO MD 21636		
31. DATE FILED (Month, Day, Year): JAN 1 90	32. REGISTRAR'S SIGNATURE	

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89 37761

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Florence Corrie Ward

2. DATE OF DEATH: MONTH 12 DAY ~~16~~ 15 YEAR 89

3. TIME OF DEATH: 11:35 P M

4. SOCIAL SECURITY NUMBER: 222 09 1719

5. SEX: Fem. 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 07,15,13

8. BIRTHPLACE (State or Foreign Country): Delaware

9a. FACILITY NAME (If not institution, give street and number): Kent & Queen Anne's Hospital

9b. CITY, TOWN OR LOCATION OF DEATH: Chestertown

9c. COUNTY OF DEATH: Kent

RESIDENCE OF DECEDENT

10a. STATE: Maryland

10b. COUNTY: Kent

10c. CITY, TOWN OR LOCATION: RFD Chestertown

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO

10e. STREET AND NUMBER: Rte # 3 Country Club Estates

10f. ZIP CODE: 21620

10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: Married
1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO
IF YES, GIVE WAR OR DATES: No

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)
1 ☐ YES 2 ☒ NO Specify: No

14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): 4 College (1-4 or 5+):

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Secretary

16b. KIND OF BUSINESS/INDUSTRY: Board of Education

17. FATHER'S NAME (First, Middle, Last): Elmer P. Corrie

18. MOTHER'S NAME (First, Middle, Maiden Surname): Alice Stewart

19a. INFORMANT'S NAME (Type/Print): Ellery J. Ward (Husband)

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rte # 3 RFD Country Club Estates

20a. METHOD OF DISPOSITION: ☒ 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Burial

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Paul's Cemetery (12/19/89)

20c. LOCATION — City or Town, State: Chestertown, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: J. Willis Wells

22. NAME AND ADDRESS OF FACILITY: J. Willis Wells P.O. Box # 264 Chestertown, Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary heart disease

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

chronic atrial fibrillation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert W. Farr

29c. LICENSE NUMBER: D 01250

29d. DATE SIGNED (Month, Day, Year): 12-18-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Robert W. Farr, M.D. Chestertown, MD 21620

31. DATE FILED (Month, Day, Year): DEC 18 '89

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

10

OHMH-1S Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

89-37762

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY GIRL BRANDENBERG
2. DATE OF DEATH (Month, Day, Year): 12 - 24 - 89
3. TIME OF DEATH: 1510 M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: MIN. 44
7. DATE OF BIRTH (Month, Day, Year): 12-24-89
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): ST. AGNES HOSPITAL 900 CATON AVENUE
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: BALTIMORE COUNTY

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: Balto.
10c. CITY, TOWN OR LOCATION: Balto.
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3556 Benzinger Rd.
10f. ZIP CODE: 21229
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last):
18. MOTHER'S NAME (First, Middle, Maiden Surname): Kimberly L. Brandenburg
19a. INFORMANT'S NAME (Type/Print): Brandenburg, Kimberly
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3556 Benzinger Rd. Balto MD 21229
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): NEW CATHEDRAL CEMETERY
20c. LOCATION — City or Town, State: BALTIMORE, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. EXTREME PREMATURITY
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. PRETERM LABOR + DELIVERY
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶ 12/24/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): J.R.SAN MARTIN — ST. AGNES HOSPITAL 900 CATON AVE. — BALTIMORE
31. DATE FILED (Month, Day, Year): JAN 17 1990
32. REGISTRAR'S SIGNATURE: Gina Davidson-Randall

DHMH-16 Rev 1/89

89-37763

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Edith Margaret FINE

2. DATE OF DEATH: MONTH 12 DAY 25 YEAR 1989

3. TIME OF DEATH: 11 59 A M

4. SOCIAL SECURITY NUMBER: 218-04-1864

5. SEX: 1 ☐ M 2 ☒ F

6. AGE (In yrs. last birthday): 67 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.

7. DATE OF BIRTH (Month, Day, Year): 3/11/22

8. BIRTHPLACE (State or Foreign Country): –

9a. FACILITY NAME (If not institution, give street and number): FRANKLIN SQUARE HOSPITAL

9b. CITY, TOWN OR LOCATION OF DEATH:

9c. COUNTY OF DEATH: Baltimore County

RESIDENCE OF DECEDENT

10a. STATE: MD.

10b. COUNTY: BALTIMORE

10c. CITY, TOWN OR LOCATION:

10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER: 1624 H DOOLITTLE RD.

10f. ZIP CODE: 21221

10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES –

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: –

14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): – College (1-4 or 5+): –

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): –

16b. KIND OF BUSINESS/INDUSTRY: –

17. FATHER'S NAME (First, Middle, Last): –

18. MOTHER'S NAME (First, Middle, Maiden Surname): –

19a. INFORMANT'S NAME (Type/Print): –

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): –

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):

20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald O'Neill 2-15-90

22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BOARD, BALTO., MD. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Septic Shock	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status Post Bilateral Below Knee Amputation

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY: M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: P. Joyce MD

29c. LICENSE NUMBER: NA

29d. DATE SIGNED (Month, Day, Year): 12- 25 - 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): P. Joyce, MD 9000 Franklin Square Drive Baltimore, Maryland 21237

31. DATE FILED (Month, Day, Year):

32. REGISTRAR'S SIGNATURE:

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Knee Amputation

89-37764

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): EDith P. Scott			2. DATE OF DEATH (Month, Day, Year): 12 31 1989	3. TIME OF DEATH: 12:15A M
4. SOCIAL SECURITY NUMBER: 212-74-5162	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 97 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 12-9-1892	8. BIRTHPLACE (State or Foreign Country): Va.
9a. FACILITY NAME (If not institution, give street and number): P.O. Box 37		9b. CITY, TOWN OR LOCATION OF DEATH: Hurlock		9c. COUNTY OF DEATH: Dorchester
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Hurlock, Maryland 21643		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: P.O. Box 37		10f. ZIP CODE: 21643		10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker		16b. KIND OF BUSINESS/INDUSTRY: Housewife
17. FATHER'S NAME (First, Middle, Last): William Miles		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattie Simms		
19a. INFORMANT'S NAME (Type/Print): Ruth Scott		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 37 Hurlock, Md. 21643		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Unity Washington		20c. LOCATION — City or Town, State: Hurlock, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Hob		22. NAME AND ADDRESS OF FACILITY: Williamson Funeral HOme 311 S. Main Street Fed., Md. 21632		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congestive heart failure	3 weeks
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. myocarditis	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Acute myocardial infarction	2 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Old age-

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [illegible] MD	29c. LICENSE NUMBER: 257	29d. DATE SIGNED (Month, Day, Year): ▶1-10-90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Carlos F. BARROSO		
31. DATE FILED (Month, Day, Year): JAN 22 '90	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37765

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: DELPHIA MAY MINER
2a. DATE OF DEATH MONTH DAY YEAR: FEBRUARY 24, 1989
2b. HOUR: 7:30 AM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH MONTH DAY YEAR: July, 23, 1901
6. AGE (IN YEARS LAST BIRTHDAY): 87 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITA;
12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE): Homemaker
12b. KIND OF BUSINESS OR INDUSTRY: Own Home

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)
13a. STATE: Maryland
13b. COUNTY: Garrett
13c. CITY OR TOWN: Grantsville
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET ADDRESS: Route 2, Box 321 21536

14. FATHER'S NAME FIRST MIDDLE LAST: Henry Platter
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Jemima Handwerk
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES)
16b. SOCIAL SECURITY NO.: 215369814
17. INFORMANT ADDRESS: Rt. 2, Box 321 Victor C. Miner Grantsville, MD 215[illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD — 16 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Renal Failure

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)
21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from [illegible] 19 88, to [illegible] 19[illegible], that (I) (we) last saw the deceased alive on 2-22 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.
22b. SIGNATURE: [illegible]
DEGREE: ATTENDING PHYSICIAN ☒ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐
22c. DATE SIGNED: 2/25/89
22d. PHYSICIAN'S NAME (TYPE OR PRINT): EUGENE V. MAZZOCCO, M.D.
22e. ADDRESS: 912 SETON DRIVE CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial
23b. DATE: 2/27/89
23c. NAME OF CEMETERY OR CREMATORY: Grantsville Cemet.
23d. LOCATION CITY OR TOWN COUNTY STATE: Grantsville, Garrett, MD
24. FUNERAL DIRECTOR: [illegible] Grantsville, MD
25a. DATE REC'D. BY REGISTRAR: MAR 01 1989
25b. REGISTRAR'S SIGNATURE: Julia Davidson Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR ~~STATE~~ REGISTRAR

REG. NO. 89-37766

1. DECEASED NAME (TYPE OR PRINT) First: EDNA	Middle: MERLE	Last: SISLER	2. DATE OF DEATH Month Day Year: FEBRUARY 27, 1989	2a. HOUR: 1:45P M	M
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH Month Day Year: August 3rd, 1919	6. AGE (IN YEARS LAST BIRTHDAY): 69 YRS	If UNDER 1 YEAR Months / Days	If UNDER 24 HRS Hours / Min.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): West Virginia	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.		MD OR
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (TYPE OF WORK DONE DURING MOST OF WORKING LIFE): Home Maker	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	Garrett	Friendsville	YES ☐ NO ☒	Rt. 1 Box 276 21531

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Haman / / Rodeheaver	Ada / Myrtle / Reckart

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. IF YES, GIVE WAR OR DATES	16c. SOCIAL SECURITY NO.	17. INFORMANT / ADDRESS
No		219 46 1842	Don E. Sisler Same as #13 above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aorta ; M yocardial Infarct
DUE TO, OR AS A CONSEQUENCE OF (b): C.H.F. Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c): M Fibrillation Respiratory Failure
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE

22a. I certify that (I) (this hospital) attended the deceased from 2-22 19 89, to 2-27 19 89, that (I) (we) last saw the deceased alive on 2-27 19 89, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	MD, ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
URIEL VELANDIA, M.D.	924 SETON DRIVE, CUMBERLAND, MD 21502

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Burial	March 2, 1989	Blooming Rose Cem.	Friendsville Garrett MD

24. FUNERAL DIRECTOR NAME	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Newman Funeral Home, Russell K. Newman 155 Main St. Grantsville, MD 21536	MAR 01 1989	Julia Durham-Kendall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH - 16 50M 1/81 (VRA 15, 4)

5 157 99 39 A

MILLER, 03/13/43 89-37767

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
JAMES	MILLER	NOVEMBER 9, 1989	3:35 A M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
216-68-4593	1 [X] M 2 [ ] F	47 YRS.			MAR. 12, 1942	VIRGINIA

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
THE JOHNS HOPKINS HOSPITAL	BALTIMORE CITY	BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND		BALTIMORE	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
UNKNOWN	UNKNOWN	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEOENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
7		LABORER	CITY OF RICHMOND

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
SAM THOMAS PERKINS	DAISEY B. MASON

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
ESTHER PERKINS	813 N. 21ST. STREET - RICHMOND, VA. 23223

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	FOREST LAWN CREMATORY	RICHMOND, VIRGINIA

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Carlton T. Brooks	CARLTON T. BROOKS FUNERAL HOME 2200 HULL STREET - RICHMOND, VA. 23224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. electromechanical dissociation	3 minutes
DUE TO (OR AS A CONSEQUENCE OF):	b. acidosis	24 hours
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	c. sepsis	2 days
DUE TO (OR AS A CONSEQUENCE OF):	d. chronic infection	2 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Renal failure

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 [ ] YES 2 [X] NO	HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined		M	1 [ ] YES 2 [ ] NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)

1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.

2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Albert Burton MD	pending	▶ 11/9/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

Albert Andrew Burton 600 N. Wolfe St 21205 Baltimore MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

UNKNOWN 89-214

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37768

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 must be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 6 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): UNKNOWN 89-214			2. DATE OF DEATH (Month, Day, Year): 11-8-89	3. TIME OF DEATH: 8:20AM M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): 7901 N. Hampshire Ave.-Dock,Giant Fd.		9b. CITY, TOWN OR LOCATION OF DEATH: Langley Park		9c. COUNTY OF DEATH: Prince Georges Co.

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER	10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)		
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) in-state removal	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Ronald A Wade 3-15-90	22. NAME AND ADDRESS OF FACILITY: STATE ANATOMY BAORD, BALTO., MD. 21201		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 XX Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural XXX 2 Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) 11-8-89	28b. TIME OF INJURY 5:09AM	28c. INJURY AT WORK? 1 ☐ YES XX NO	28d. DESCRIBE HOW INJURY OCCURED: Pedestrian struck by tractor trailer
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Dock-grocery store			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Giant Food, 7901 N. Hampshire Avenue, Langley Park,MD

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year) ▶ 11-8-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan,MD — 111 Penn Street,baltimore,MD 21201 VC		
31. DATE FILED (Month, Day, Year) MAR 19 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37769

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician. Items 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bernard Aaron Adams			2. DATE OF DEATH: Month 12/30 Day Year 89		3. TIME OF DEATH: 6:15P M
4. SOCIAL SECURITY NUMBER: 362-52-0391	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 37 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Jan. 1, 1952
8. BIRTHPLACE (State or Foreign Country): Michigan					
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT					
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO	
10a. STREET AND NUMBER: 1415 Key Parkway C-1		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4+	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Public Relations		16b. KIND OF BUSINESS/INDUSTRY: Education/ Community Colleg	
17. FATHER'S NAME (First, Middle, Last): Milton Daniel Adams		18. MOTHER'S NAME (First, Middle, Maiden Surname): Freddie Mae Givens			
19a. INFORMANT'S NAME (Type/Print): Mrs. Toni E. Adams		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1415 Key Parkway, C-1, Frederick, Maryland 21701			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens		20c. LOCATION — City or Town, State: Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Kathryn Roberson M00706		22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 East Church St., Frederick, MD 21701			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Subarachnoid Hemorrhage

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the ceuse(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
John Anthony Vitarello MD	D27544	▶ 12/30/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): John A. Vitarello, MD 310 West Ninth Street, Frederick, Maryland 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 1990	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37770

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Oscar Brandenburg
2. DATE OF DEATH (Month, Day, Year): 12/27/89
3. TIME OF DEATH: 00:45 M
4. SOCIAL SECURITY NUMBER: 218-30-8685
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): 56 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN.
7. DATE OF BIRTH (Month, Day, Year): Jan. 17, 1933
8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Frederick
9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Frederick
10c. CITY, TOWN OR LOCATION: Mount Airy
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 13849 Penn Shop Rd.
10f. ZIP CODE: 21771
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES: Korean
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.): 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9 — College (1-4 or 8+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Body Shop Mechanic
16b. KIND OF BUSINESS/INDUSTRY: County Government
17. FATHER'S NAME (First, Middle, Last): Rudy Leroy Brandenburg
18. MOTHER'S NAME (First, Middle, Maiden Surname): Anna Lucille Day
19a. INFORMANT'S NAME (Type/Print): Mary Ann Brandenburg
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13849 Penn Shop Rd., Mount Airy, Md. 21771
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Providence Cemetery
20c. LOCATION — City or Town, State: Kemptown, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Olin L. Molesworth
22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER
29c. LICENSE NUMBER: A31721
29d. DATE SIGNED (Month, Day, Year): 1/2/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey N. Lowen MD 310 W. 5th St Frederick MD 21701

31. DATE FILED (Month, Day, Year): JAN 2 1990
32. REGISTRAR'S SIGNATURE

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-18 Rev 1/89

1 · FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37771

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lucy Bolton Lucy M. BOLTON					2. DATE OF DEATH (Month, Day, Year): 12/30/89	3. TIME OF DEATH: 1 P M
4. SOCIAL SECURITY NUMBER: 220-09-8692D	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 76 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 9-26-13	8. BIRTHPLACE (State or Foreign Country): VA.
9a. FACILITY NAME (If not institution, give street and number): Pleasant Views Nrsg. Home		9b. CITY, TOWN OR LOCATION OF DEATH: Mt. Airy MD			9c. COUNTY OF DEATH: Carroll	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: Diamond Ave.		10f. ZIP CODE: 20877	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home	
17. FATHER'S NAME (First, Middle, Last): Robert B. Inscore		18. MOTHER'S NAME (First, Middle, Maiden Surname): Rachel J. Hill	
19a. INFORMANT'S NAME (Type/Print): Katherine R. Strouth		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): R#2, Box 253, Inwood, W. Va. 25428	
20a. METHOD OF DISPOSITION: ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens	20c. LOCATION — City or Town, State: Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth		22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cerebral vascular accidents	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Senile atherosclerosis	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Coronary artery disease + pacemaker, Alzheimers, Endometrial Carcinoma

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D0658	29d. DATE SIGNED (Month, Day, Year): ▶ 1/2/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 2009 Century Plaza Columbia MD 21044		
31. DATE FILED (Month, Day, Year): JAN 2 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIEN
CERTIFICATE OF DEATH

REG. NO. 89-37772

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Freda Long Cramer — Freda Lillian Long Cramer			2. DATE OF DEATH: MONTH 12 / DAY 4 / YEAR 89	3. TIME OF DEATH: 445 A.M.
4. SOCIAL SECURITY NUMBER: 534-24-2637	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 89 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 6/2/1900	8. BIRTHPLACE (State or Foreign Country): Iowa
9a. FACILITY NAME (If not institution, give street and number): Citizens Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1706 Springhouse Court		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cashier		16b. KIND OF BUSINESS/INDUSTRY: Theatre
17. FATHER'S NAME (First, Middle, Last): Sedric L. Long		18. MOTHER'S NAME (First, Middle, Maiden Surname): Kessie M. Arbogast Long		
19a. INFORMANT'S NAME (Type/Print): Norma Kuter		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6093 Quartz Circle, Frederick, MD 21701		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gar		20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral HOmes, PA P.O. Box 1819, Frederick, MD 210701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardiac Arrest	5 minutes
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Aortic Sclerotic C.V.D disease	10 years
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Gastric Hemorrhage

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Bernard O. Thomas	D14309	▶ 12/6/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Bernard O. Thomas 225 N. Market St. Frederick, Md. 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 06 1989	Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37773

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES RILEY CHISHOLM		2. DATE OF DEATH: MONTH 12 DAY 16 YEAR 89	3. TIME OF DEATH: 11:45 AM
4. SOCIAL SECURITY NUMBER: 247-14-3218	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 80 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): July 28, 1909
8. BIRTHPLACE (State or Foreign Country): S. Carolina			
9a. FACILITY NAME (If not institution, give street and number): Frederick Health Care Center	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Walkersville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 214 Challedon Drive	10f. ZIP CODE: 21793	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO; IF YES, GIVE WAR OR DATES: WWII	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Dir. of Finance SBA	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Jesse W. Chisholm		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mattye Iola Riley	
19a. INFORMANT'S NAME (Type/Print): Mrs. Sally Carson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 214 Challedon Drive Walkersville, MD 21793	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Smithsburg Crematory	20c. LOCATION — City or Town, State: Smithsburg, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Robert E. Dailey Jr		22. NAME AND ADDRESS OF FACILITY: Robert E. Dailey & Son Funeral Homes, PA 1201 N. Market Street Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Cardiopulmonary arrest	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b. DUE TO (OR AS A CONSEQUENCE OF):	Ventricular arrhythmia	
c. DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypothyroidism
Atherosclerotic cardiovascular disease

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [X] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ali J. Afrookteh MD	29c. LICENSE NUMBER: D 35183	29d. DATE SIGNED (Month, Day, Year): ▶ 12-18-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ali J. Afrookteh, MD 300 West 9th Street Frederick, MD 21701		
31. DATE FILED (Month, Day, Year): DEC 18 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIE
CERTIFICATE OF DEATH

REG. N 89-37774

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last) Wilbur Franklin COOK (Middle Name) Wilbur Cook Franklin			2. DATE OF DEATH MONTH DAY YEAR 12-31-89	3. TIME OF DEATH 4:45 P.M
4. SOCIAL SECURITY NUMBER 220-16-0389	5. SEX 1 X M 2 ☐ F	6. AGE (In yrs. last birthday) 64 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year) July 6, 1925	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hosptal		9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick

RESIDENCE OF DECEDENT

10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 X NO
10e. STREET AND NUMBER 4016 Ballenger Creek Pike		10f. ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? U.S.A.

11. MARITAL STATUS 1 ☐ Never Married 2 XX Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12): 11 / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Sales	16b. KIND OF BUSINESS/INDUSTRY Sears, Roebuck, & Co.	
17. FATHER'S NAME (First, Middle, Last) Raymond Franklin Buchanan Smith Cook		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian May Fogle	
19a. INFORMANT'S NAME (Type/Print) Mrs. Floretta Cook		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 Ballenger Creek Pike, Frederick, Md. 21701	
20a. METHOD OF DISPOSITION XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Manor Cemetery	20c. LOCATION — City or Town, State Frederick, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶ Richard E. Ford M00255	22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CVA - Cerebral Infarction	1WK
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 X NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH 1 X Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER Robert L. Kaufmann MD	29c. LICENSE NUMBER D13971.	29d. DATE SIGNED (Month, Day, Year) ▶ 12/31/89.
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert L. Kaufmann MD	300 West Ninth Street, Frederick, Md. 21701	
31. DATE FILED (Month, Day, Year) JAN 04 1990	32. REGISTRAR'S SIGNATURE Julie Wilson Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37775

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Glenn David Delauter			2. DATE OF DEATH (Month, Day, Year): Dec. 13, 1989	3. TIME OF DEATH: 11:58 P. M
4. SOCIAL SECURITY NUMBER: 216-05-9202	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 74 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): Feb. 19, 1915	8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick, Md.		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Middletown	10d. IHSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND HUMBER: 8022 Myersville Rd.	10f. ZIP CODE: 21769		10g. CITIZEN OF WHAT COUHTRY?: U.S.A.

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IH U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES X	13. WAS DECEHDENT OF HISPANIC ORIGIH? (Specify Yes or Ho— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] HO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7; College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): carpenter	16b. KIHD OF BUSIHESS/IHDUSTRY: construction	
17. FATHER'S HAME (First, Middle, Last): Alvey Delauter	18. MOTHER'S HAME (First, Middle, Maiden Surname): Fannie Shepley		
19a. IHFORMANT'S HAME (Type/Print): Helen Delauter	19b. MAILIHD ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8022 Myersville Rd., Middletown, Md. 21769		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Lutheran Cemetery	20c. LOCATION — City or Town, State: Middletown, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald B. Thompson	22. NAME AND ADDRESS OF FACILITY: Donald B. Thompson Funeral Home 31 E. Main St., MIddletown, Md. 21769		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complicetions that caused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arreat, ahock, or heart failure. List only one causa on aach line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Finel disease or condition resulting in death) →	a. ARTERIO-SCLEROTIC CARDIO-VASCULAR DIS.	
	DUE TO (OR AS A CONSEQUEHCE OF):	
Sequentielly liat conditions, if any, leading to immedieta cause. Enter UNDERLYING CAUSE (Disease or injury that initiated eventa resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUEHCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Insulin dependent Diabetes millitus

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMIHER? 1 [ ] YES 2 [ ] HO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. IHJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIND PHYSICIAH: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, data and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Gregory L. Smith M.D	29c. LICENSE HUMBER: 40587	29d. DATE SIOHED (Month, Day, Year): ▶ 12/14/89
30. HAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		
31. DATE FILED (Month, Day, Year): DEC 18 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYG
CERTIFICATE OF DEATH

REG. 89 37776

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mamie Elmira Day		2. DATE OF DEATH (Month, Day, Year): December 30, 1989	3. TIME OF DEATH: 1230 P M
4. SOCIAL SECURITY NUMBER: 218-24-3277	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 91 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Jan. 4, 1898
8. BIRTHPLACE (State or Foreign Country): Maryland			

9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Gaithersburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 16505 Henry Drive	10f. ZIP CODE: 20877		10g. CITIZEN OF WHAT COUNTRY?: American

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☒ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8; College (1-4 or 6+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): John Henry Cordell	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ellen Stream
19a. INFORMANT'S NAME (Type/Print): Mary E. Meadows	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 16505 Henry Drive, Gaithersburg, Md. 20877

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Clarksburg Meth. Cemetery	20c. LOCATION — City or Town, State: Clarksburg, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert L. Williams	22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A., Funeral Home, Damascus, Maryland 20872	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiac Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. arteriosclerotic heart disease
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Dehydration
Chronic arteriosclerosis
Cerebral vascular Disease

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D.	29c. LICENSE NUMBER: D26499	29d. DATE SIGNED (Month, Day, Year): ▶ 12/30/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ronald E. Miller, M.D. 4 Culwell Drive, Mt. Airy, Md. 21771		
31. DATE FILED (Month, Day, Year): JAN 2 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37777

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cora E. Fogle				2. DATE OF DEATH (Month, Day, Year): 12 / 31 / 89	3. TIME OF DEATH: 5:50 A M
4. SOCIAL SECURITY NUMBER: 220-42-5509	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 94 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)		7. DATE OF BIRTH (Month, Day, Year): 1-12-95	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Reeders Memorial Home		9b. CITY, TOWN OR LOCATION OF DEATH: Boonsboro		9c. COUNTY OF DEATH: Washington	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Boonsboro	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 141 S. Main Street		10f. ZIP CODE: 21713	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 3rd or 4th grade; College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): William H. Baugher	18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Ann
19a. INFORMANT'S NAME (Type/Print): Mrs. Vivian Masser	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5032 Old National Pike, Frederick, MD 21701

20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Harmony Cemetery	20c. LOCATION — City or Town, State: Myersville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Richard E. Graf M00255	22. NAME AND ADDRESS OF FACILITY: Keeney & Basford PA Funeral Home 106 E. Church St., Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiovascular disease / Arrhythmia

DUE TO (OR AS A CONSEQUENCE OF):
b. ~~Congestive Heart failure~~ cvrd Respiratory Insufficiency

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c. Sick Sinus Syndrome

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Congestive Heart Failure
Organic Brain Syndrome

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☒ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Martha A. Pendleton Rigole M.D.	29c. LICENSE NUMBER: D38968	29d. DATE SIGNED (Month, Day, Year) ▶ 12/31/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Martha A. Pendleton Rigole		
31. DATE FILED (Month, Day, Year): JAN 05 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37778

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Frank B. Fletcher / FRANK B. FLETCHER					2. DATE OF DEATH (Month, Day, Year): 12/30/89	3. TIME OF DEATH: 6:00 PM
4. SOCIAL SECURITY NUMBER: 214-10-2082	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 02/16/1901	8. BIRTHPLACE (State or Foreign Country): Brunswick, MD
8a. FACILITY NAME (If not institution, give street and number): 210 Ridgeville Blvd.			9b. CITY, TOWN OR LOCATION OF DEATH: Mt. Airy		9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: 210 Ridgeville Blvd., Mt. Airy	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: 210 Ridgeville Blvd.		10f. ZIP CODE: 21771	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 7 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Fireknocker	16b. KIND OF BUSINESS/INDUSTRY: B&O RR, Brunswick, MD	
17. FATHER'S NAME (First, Middle, Last): Robert J. Fletcher		18. MOTHER'S NAME (First, Middle, Maiden Surname): Susan R. Unknown	
19a. INFORMANT'S NAME (Type/Print): Esther C. Bailey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4213 Bonner Rd., Baltimore, Maryland 21216	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial Gardens	20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barbara A. Williams, Funeral Dir.		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home, 100 Petersville Rd., Brunswick, MD 21716	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIOPULMONARY ARREST

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. PROBABLE CEREBRAL-VASCULAR ACCIDENT

DUE TO (OR AS A CONSEQUENCE OF):

c. ARTERIO SCLEROSIS

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D	29c. LICENSE NUMBER: D26 499	29d. DATE SIGNED (Month, Day, Year): ▶ 12-30-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Ronald E. Miller, MD, 4 Culwell Dr., Mt. Airy, Maryland 21771		
31. DATE FILED (Month, Day, Year): JAN 18 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-1S Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37779

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Items 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): GEORGE FRANCIS HAKY			2. DATE OF DEATH (Month, Day, Year): 11 29 89	3. TIME OF DEATH: 0545 AM
4. SOCIAL SECURITY NUMBER: 174-18-9678	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 69 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 4/4/20	8. BIRTHPLACE (State or Foreign Country): Pennsylvania
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 1305 Taney Avenue		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☑ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES: WW II	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Brick Layer	16b. KIND OF BUSINESS/INDUSTRY: Carnegie Illinois Steel	
17. FATHER'S NAME (First, Middle, Last): Joseph Haky		18. MOTHER'S NAME (First, Middle, Maiden Surname): Barbara Haky	
19a. INFORMANT'S NAME (Type/Print): Helen Heim Haky		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1305 Taney Avenue, Frederick, MD 21701	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Brenda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory arrest

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. extensive transitional cell

DUE TO (OR AS A CONSEQUENCE OF):

c. ca of bladder

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year); 28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: D 14626	29d. DATE SIGNED (Month, Day, Year): ▶ 12/5/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): [illegible]		
31. DATE FILED (Month, Day, Year): DEC 05 1989	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37780

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Cecil Richard Harrison				2. DATE OF DEATH (Month, Day, Year): 12 / 08 / 89	3. TIME OF DEATH: 9:15 P M
4. SOCIAL SECURITY NUMBER: 525-60-1422	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 61 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 12/08/1928	8. BIRTHPLACE (State or Foreign Country): Cumberland, MD
9a. FACILITY NAME (If not institution, give street and number): Residence 1121 Rosemont Drive			9b. CITY, TOWN OR LOCATION OF DEATH: Knoxville		9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT						
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Knoxville		10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: 1121 Rosemont Drive			10f. ZIP CODE: 21758		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES: WWII		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 2			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineer		16b. KIND OF BUSINESS/INDUSTRY: Chessie Systen Div. (Cumo)	
17. FATHER'S NAME (First, Middle, Last): Charles Edward Harrison					18. MOTHER'S NAME (First, Middle, Maiden Surname): Margaret Virginia Didiwick	
19a. INFORMANT'S NAME (Type/Print): Elsie M. Harrison			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1121 Rosemont Drive, Knoxville, MD 21758			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery		20c. LOCATION — City or Town, State: Petersville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams, Funeral Dir.			22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home 100 Petersville Rd., Brunswick, MD 21716			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Extensive hyper nephroma DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneu by hum-wood tumor DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
P. Gregory Ranseh, M.D.	D14C 3C	▶ 12/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 501 W. 7th Street, Frederick, MD 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 08 1990	Julia Davidson-Randall

DHMH-16 Rev 1/89

12

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYG
CERTIFICATE OF DEATH

REG. 89-37781

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): James Francis McMurry (James Francis McMurry)			2. DATE OF DEATH (Month, Day, Year): Dec 16 1989	3. TIME OF DEATH: 12 30 P M
4. SOCIAL SECURITY NUMBER: 214-09-3588	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 77 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 08/18/1912	8. BIRTHPLACE (State or Foreign Country): Brunswick, MD
9a. FACILITY NAME (If not institution, give street and number): Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Hagerstown		9c. COUNTY OF DEATH: Washington

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Brunswick	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 209 N. Delaware Avenue		10f. ZIP CODE: 21716	10g. CITIZEN OF WHAT COUNTRY?: United States

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Conductor	16b. KIND OF BUSINESS/INDUSTRY: Chessie System/B&O RR	
17. FATHER'S NAME (First, Middle, Last): John Anthony McMurry		18. MOTHER'S NAME (First, Middle, Maiden Surname): Lula Darr	
19a. INFORMANT'S NAME (Type/Print): Rosalee E. McMurry		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 209 N. Delaware Avenue, Brunswick, Md. 21716	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. Olivet Cemetery	20c. LOCATION — City or Town, State: Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams Barbara A. Williams, Funeral Dir.		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home 100 Petersville Road, Brunswick, Md. 21716	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Head Trauma	31 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

① Congestive Heart Failure
② Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [X] YES 2 [ ] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): Oct 26, 1989	28b. TIME OF INJURY: 2 30 P M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO
	28d. DESCRIBE HOW INJURY OCCURED: Struck head on Dashboard		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Potomac St + R.R. tracks	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): Brunswick, Md	

29a. CERTIFIER (Check only one): 1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Edward W. Dittoe M.D.	29c. LICENSE NUMBER: D01062	29d. DATE SIGNED (Month, Day, Year): ▶ Dec 16, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Edward W. Dittoe III, M.D. 217 W. Washington St Hagerstown, Md 21740

31. DATE FILED (Month, Day, Year): JAN 08 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Pondexter

OHMH-16 Rev 1/89

8

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37782

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Anna Louise Merriman / ANNA LOUISE MERRIMAN			2. DATE OF DEATH (Month / Day / Year): 12 / 18 / 1989	3. TIME OF DEATH: 7:55 A M
4. SOCIAL SECURITY NUMBER: 213-16-1711	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 07/06/1904	8. BIRTHPLACE (State or Foreign Country): Maryland / Frederick County
9a. FACILITY NAME (If not institution, give street and number): Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Brunswick	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 109 East "A" Street		10f. ZIP CODE: 21716	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Cook	16b. KIND OF BUSINESS/INDUSTRY: B&O YMCA-Brunswick, MD	
17. FATHER'S NAME (First, Middle, Last): Edward Webster Merriman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Catherine Anderson	
19a. INFORMANT'S NAME (Type/Print): William M. Merriman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4304 Horine Court, Jefferson, MD 21755	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mark's Cemetery	20c. LOCATION — City or Town, State: Petersville, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barbara A. Williams, Funeral Dir.		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home, 100 Petersville Rd., Brunswick, MD 21716	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CONGESTIVE HEART FAILURE	3 WKS
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	MYOCARDIAL INFARCTION	3 WKS
DUE TO (OR AS A CONSEQUENCE OF):		
c.		
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Wayne Allgaier MD		29c. LICENSE NUMBER: D-16675	29d. DATE SIGNED (Month, Day, Year): ▶ 12/18/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): WAYNE ALLGAIER, M.D., BRUNSWICK, MD 21716			
31. DATE FILED (Month, Day, Year): JAN 08 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall		

DHMH-18 Rev 1/89

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37783

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Lee Joseph Rowan			2. DATE OF DEATH (Month, Day, Year): 12 / 30 / 1989	3. TIME OF DEATH: 9:05 P M
4. SOCIAL SECURITY NUMBER: 326-10-5244	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 73 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11/03/1916	8. BIRTHPLACE (State or Foreign Country): Chicago, ILL
9a. FACILITY NAME (If not institution, give street and number): 37 East "D" Street		9b. CITY, TOWN OR LOCATION OF DEATH: Brunswick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Brunswick	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 37 East "D" Street		10f. ZIP CODE: 21716	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12; College (1-4 or 6+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operating Engineer	16b. KIND OF BUSINESS/INDUSTRY: Construction	
17. FATHER'S NAME (First, Middle, Last): John Martin Rowan		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ida Olson	
19a. INFORMANT'S NAME (Type/Print): Patsy L. Rowan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 37 East "D" Street, Brunswick, Md. 21716	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. Mary's Cemetery	20c. LOCATION — City or Town, State: Petersville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Barbara A. Williams, Funeral Dir. Barbara A. Williams, Funeral Dir.		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home 100 Petersville Rd., Brunswick, MD 21716	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARCINOMA OF LUNG	~ 14 mos.
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12/30/89	28b. TIME OF INJURY: M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Michael S. Rudman, MD. Physician	D17106	▶ 1-3-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHAEL S. RUDMAN, MD. PO Box 17 Middletown, MD. 21769

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 18 1990	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37784

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Ernest George Strecker (Ernest G. Strecker)			2. DATE OF DEATH: MONTH 12 DAY 5 YEAR 89	3. TIME OF DEATH: 6:50 P M
4. SOCIAL SECURITY NUMBER: 325-01-7424	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 85 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.)	7. DATE OF BIRTH (Month, Day, Year): 11-18-1904	8. BIRTHPLACE (State or Foreign Country): Germany
9a. FACILITY NAME (If not institution, give street and number): Northhampton Manor Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick		10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 7081 Catalpa Road		10f. ZIP CODE: 21701		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Meat Cutter		16b. KIND OF BUSINESS/INDUSTRY: Central Super Mart
17. FATHER'S NAME (First, Middle, Last): Frederick Strecker		18. MOTHER'S NAME (First, Middle, Maiden Surname): Magdaline Laidig Strecker		
19a. INFORMANT'S NAME (Type/Print): Elizabeth Marie Hellmann Strecker		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 7081 Catalpa Rd., Frederick, MD 21701		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Waldheim Cemetery		20c. LOCATION — City or Town, State: Forest Park, Ill.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ D. Douglas Stauffer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	10 Days
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Parkinsonism	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☒ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert L. Kaufmann MD	D-13971	▶ 12/6/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 07 1989	Julia Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37785

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): THELMA W Thelma Wenner Smith SMITH				2. DATE OF DEATH (Month, Day, Year): 12 25 89	3. TIME OF DEATH: 1300 M
4. SOCIAL SECURITY NUMBER: 216-22-1861	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 01/15/1918	8. BIRTHPLACE (State or Foreign Country): Frederick County MD
9a. FACILITY NAME (If not institution, give street and number): Residence - 6 5th Avenue			9b. CITY, TOWN OR LOCATION OF DEATH: Brunswick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Brunswick	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 6 5th Avenue		10f. ZIP CODE: 21716	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIOIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Housewife	16b. KIND OF BUSINESS/INDUSTRY: Homemaker	
17. FATHER'S NAME (First, Middle, Last): Unknown		18. MOTHER'S NAME (First, Middle, Maiden Surname): Nellie Wenner	
19a. INFORMANT'S NAME (Type/Print): Lucy Rutherford	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): P.O. Box 175 Harpers Ferry, West Virginia 25425		
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Park Heights Cemetery	20c. LOCATION — City or Town, State: Brunswick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams, Funeral Dir.	22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home 100 Petersville Rd., Brunswick, Md. 21716		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit and should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
DUE TO (OR AS A CONSEQUENCE OF):
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☒ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Robert R Roberts MD	29c. LICENSE NUMBER: D09867	29d. DATE SIGNED (Month, Day, Year): ▶ 12/25/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RRR ROBERTS MD 15 W 7th St Frederick MD 21701-4599		
31. DATE FILED (Month, Day, Year): JAN 08 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37786

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ORION Orion Jacob Virts / J. Virts			2. DATE OF DEATH: MONTH 12 DAY 28 YEAR 89 (DEC. 28 1989)	3. TIME OF DEATH: 0105 M
4. SOCIAL SECURITY NUMBER: 213-42-1879	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 85 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09/20/1904	8. BIRTHPLACE (State or Foreign Country): Lovettsville VA
9a. FACILITY NAME (If not institution, give street and number): Homewood Retirement Center		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick		9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Brunswick	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 709 East Potomac Street		10f. ZIP CODE: 21716	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 / College (1-4 or 5+): 1	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mail Carrier and Clerk	16b. KIND OF BUSINESS/INDUSTRY: U.S. Postal Service, Brunswick Post Office	
17. FATHER'S NAME (First, Middle, Last): David Elton Virts		18. MOTHER'S NAME (First, Middle, Maiden Surname): Ella Virginia Boyer	
19a. INFORMANT'S NAME (Type/Print): Gary M. Virts		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 744 Jefferson Pike, Knoxville, MD 21758	
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Union Cemetery	20c. LOCATION — City or Town, State: Lovettsville, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Barbara A. Williams / Barbara A. Williams, Funeral Dir.		22. NAME AND ADDRESS OF FACILITY: John T. Williams Funeral Home, 100 Petersville Rd., Brunswick, MD 21716	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. UREMIA — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. NEPHROSCLEROSIS — DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: PNEUMONIA ; G.I. Bleed Etiology unk.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [X] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: George I. Smith Jr MD	29c. LICENSE NUMBER: D 10587	29d. DATE SIGNED (Month, Day, Year): 12/28/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): George I. Smith, Jr. MD, 300 W. 9th Street, Frederick, Md. 21701

31. DATE FILED (Month, Day, Year): JAN 16 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37787

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

B

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BETTY KATHERINE WILES		2. DATE OF DEATH (Month, Day, Year): December 31 1989	3. TIME OF DEATH: 2210 P M
4. SOCIAL SECURITY NUMBER: 214-28-5234	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 58 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 10/29/31 — 8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Frederick	9c. COUNTY OF DEATH: Frederick

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: Frederick	10c. CITY, TOWN OR LOCATION: Frederick	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 10602 Bethel Road		10f. ZIP CODE: 21701	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☑ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): nurses' aide	16b. KIND OF BUSINESS/INDUSTRY: nursing home	
17. FATHER'S NAME (First, Middle, Last): Robert W. Eaton, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Catherine Helen McBride	
19a. INFORMANT'S NAME (Type/Print): Harold E. Wiles		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 10602 Bethel Rd., Frederick, Md. 21701	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 8 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Resthaven Memorial	20c. LOCATION — City or Town, State: Frederick, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Wanda L Lemmer		22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Home, 1621 Opossumtown Pike, Frederick, MD. 2170	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Adenocarcinoma of lung.	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Anemia

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 8 ☐ Pending investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☑ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: MD

29c. LICENSE NUMBER: 026 499

29d. DATE SIGNED (Month, Day, Year): ▶ 1-1-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year): JAN 3 1990

32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37788

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Mary A. WATKINS (Mary Watkins)					2. DATE OF DEATH MONTH 12 DAY 29 YEAR 89		3. TIME OF DEATH 0105 AM
4. SOCIAL SECURITY NUMBER: 218-46 0156	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 15, 1908	8. BIRTHPLACE (State or Foreign Country): Penn.
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick				9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT								
10a. STATE: Maryland	10b. COUNTY: Montgomery		10c. CITY, TOWN OR LOCATION: Damascus				10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
10e. STREET AND NUMBER: 28440 Honeysuckle Dr.				10f. ZIP CODE: 20872			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Teacher				16b. KIND OF BUSINESS/INDUSTRY: School	
17. FATHER'S NAME (First, Middle, Last): Frank Allsip					18. MOTHER'S NAME (First, Middle, Maiden Surname): Sarah H. Bloomer			
19a. INFORMANT'S NAME (Type/Print): J. Latimer Watkins			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 28440 Honeysuckle Dr., Damascus, Md. 20872					
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oakland Cemetery				20c. LOCATION — City or Town, State: Indiana, Pa.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Olin L. Molesworth			22. NAME AND ADDRESS OF FACILITY: Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Myocardial Infarction

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D36724	▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Jeffrey H Lowe 310 W. 9th St Frederick MD 21701

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JAN 2 1990	Julia Davidson-Randall

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37789

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julius Homer Martin				2. DATE OF DEATH (Month, Day, Year): Dec. 5 1989			3. TIME OF DEATH: 10:20 P M
4. SOCIAL SECURITY NUMBER: 215-20-3341	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 3/11/14		8. BIRTHPLACE (State or Foreign Country): Washington, DC
9a. FACILITY NAME (If not institution, give street and number): Frederick Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Frederick			9c. COUNTY OF DEATH: Frederick	
RESIDENCE OF DECEDENT							
10a. STATE: Maryland	10b. COUNTY: Frederick		10c. CITY, TOWN OR LOCATION: Frederick			10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO	
10e. STREET AND NUMBER: 6902 Yew Court			10f. ZIP CODE: 21701			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO IF YES, GIVE WAR OR DATES		13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Engineering Tech.			16b. KIND OF BUSINESS/INDUSTRY: Nat'l Bureau Standards	
17. FATHER'S NAME (First, Middle, Last): Julius John Martin			18. MOTHER'S NAME (First, Middle, Maiden Surname): Hattie Bliss Merrill Martin				
19a. INFORMANT'S NAME (Type/Print): Marion J. Martin			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 6902 Yew Court, Frederick, MD 21701				
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery			20c. LOCATION — City or Town, State: Suitland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ H. Douglas Stauffer			22. NAME AND ADDRESS OF FACILITY: Stauffer Funeral Homes, PA P.O. Box 1819, Frederick, MD 21701				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory failure	25 d
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Pneumonia	11 "
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Parkinsons dis	5 yr.
	DUE TO (OR AS A CONSEQUENCE OF):	
	d. ~~Fracture of L hip~~	30 d

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Fracture of Right hip

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☑ YES 2 ☐ NO

24. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☑ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
11-5-89	AM	1 ☐ YES 2 ☑ NO	FELL

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): HOME

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): 6902 Yew Court, Frederick

29a. CERTIFIER (Check only one): 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Robert P. Hughes	D05111	▶ 12/6/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 07 1989	Julia Davidson-Randall

DNMN-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MD 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be removed by the funeral director or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. Pages 1, 2, 3 should be used as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24

89-37790

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
John	Todd	Merritt	10-24-89	5:45PM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-07-9047	1 [X] M 2 [ ] F	82 YRS.			9-14-07	MARYLAND

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
13111 Mann Road	Glen Arm	Baltimore County

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MD.	BALTIMORE	GLEN ARM	1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
13111 MANOR ROAD	21057	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO	1 [ ] YES 2 [X] NO Specify:	Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)	RET. DEVELOPER	REAL ESTATE

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
JOHN ALONZO MERRITT	ISABELLE TODD

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
LINDA TODD BOSLEY (daughter)	13111 Manor Rd, Glen Arm, MD. 21057

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify)		

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
Joseph B. Kenhart	STATE ANATOMY BOARD, BALTO., MD. 21201

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Contact shotgun wound of left chest and abdomen	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XX [X] YES 2 [ ] NO	XX [X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
XX [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home XX [X] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident XXX [X] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	10-24-89	4:00P M	1 [ ] YES XX [X] NO	SELF INFLICTED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
HOME	13111 Mann Road, Glen Arm, Baltimore County, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Julia C. Goodin	OCME	▶ 10-25-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
Julia C. Goodin, M.D.	111 Penn Street, Baltimore, MD 21201 VC

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 4 - 1990	Julia Goodin Hendrix

DHMH-18 Rev 1/89

DUPLICATE:
ITEMS:4 thru 22 per INFORMANT
G-662 4-18-90 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37791

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JAMES MILLER		2. DATE OF DEATH (Month, Day, Year): NOVEMBER 9, 1989	3. TIME OF DEATH: 3:35 A M
4. SOCIAL SECURITY NUMBER: 217-44-3435	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 46 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): 3-4-43
8. BIRTHPLACE (State or Foreign Country): VIRGINIA			
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE	9c. COUNTY OF DEATH: BALTIMORE CITY	

RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE CITY	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4236 HARFORD ROAD		10f. ZIP CODE: 21215	10g. CITIZEN OF WHAT COUNTRY?: UNITED STATES

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 9th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): UNEMPLOYED	16b. KIND OF BUSINESS/INDUSTRY:	
17. FATHER'S NAME (First, Middle, Last): FRANKLIN MILLER	18. MOTHER'S NAME (First, Middle, Maiden Surname): DAISY MILLER (MASON)		
19a. INFORMANT'S NAME (Type/Print): CYNTHIA A MILLER	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1009 EAST LANVALE STREET BALTIMORE, MARYLAND 21202		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 8 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FORREST LAWN	20c. LOCATION — City or Town, State: RICHMOND, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: CARLTON T BROOKS 2200 HULLSTREET ROAD RICHMOND, VIRGINIA 23224		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. electromechanical dissociation — 30 MINS
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. acidosis — 24 hrs
DUE TO (OR AS A CONSEQUENCE OF):
c. Sepsis — 2 days
DUE TO (OR AS A CONSEQUENCE OF):
d. chronic infection — 2 months

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Renal Failure

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINDS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M; 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO; 28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYIND PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Albert Burton MD	29c. LICENSE NUMBER: PENDING	29d. DATE SIGNED (Month, Day, Year) ▶ 4/12/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Albert A. Burton 600 N. Wolfe st 21205 Baltimore MD

31. DATE FILED (Month, Day, Year): APR 17 1990	32. REGISTRAR'S SIGNATURE: Gina Davidson-Mendez

DHMH-18 Rev 1/89

ORIGINAL WAS MISHANDLED BY THE FUNERAL HOME
IN RICHMOND VIRGINIA: DUPLICATE WAS REISSUED
BY JOHNS HOPKINS HOSPITAL 4-16-90, INFORMATION
WAS OBTAINED BY ME FROM THE INFORMANT AND CON-
FIRMED BY THE FUNERAL HOME. CM 4-18-90

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37792

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 5 should be detached for use as the burial-transit permit. Page [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby ~~Hargorve~~ HARGROVE			2. DATE OF DEATH: MONTH 7 DAY 19 YEAR 89		3. TIME OF DEATH: 7:15 M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS 24 DAYS Wks — IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Howard County Gen Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: COLUMBIA		9c. COUNTY OF DEATH: Howard	

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?	

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Marvin Rudolph Evans	18. MOTHER'S NAME (First, Middle, Maiden Surname): Pamela Maria Grant HARGROVE	
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2213 SPILES STREET GRAND PRAIRIE TEXAS 75051-2110	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Extreme Immaturity

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M.D. A. Herrera	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ JULY 19, 1989

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): State Anatomy Board

31. DATE FILED (Month, Day, Year): APR 6 - 1990	32. REGISTRAR'S SIGNATURE: J. Julia Davidson-Randall

DHMH-18 Rev 1/89

89-37793

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY GIRL BEADS, Shara Hanna
2. DATE OF DEATH: MONTH 11 DAY 10 YEAR 89
3. TIME OF DEATH: 2:55 PM
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☑ F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS 2 — IF UNDER 24 HRS.: HOURS 2 — MIN.
7. DATE OF BIRTH (Month, Day, Year): 11 9 89
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): FRANCIS SCOTT KEY MC
9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY
9c. COUNTY OF DEATH: City

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY:
10c. CITY, TOWN OR LOCATION: Baltimore
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2251 Annapolis Road
10f. ZIP CODE: 21230
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): None Wayne Foote
18. MOTHER'S NAME (First, Middle, Maiden Surname): Vanessa Rene Beads
19a. INFORMANT'S NAME (Type/Print): Hosp/birth certif.
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2251 Annapolis Rd. Baltimore, MD 21230
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): FSKMC
20c. LOCATION — City or Town, State: Baltimore
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Francis Scott Key Medical Center
22. NAME AND ADDRESS OF FACILITY: 4940 Eastern Ave. Balt., MD 21224

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY HYPERTENSION — 4 hrs

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☑ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 11/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): CHARLES R. HAMM, JR MD 4940 EASTERN AVE, BALTIMORE 21224
31. DATE FILED (Month, Day, Year): APR 16 '90
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

Info. taken from B.C. 5/31/90 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37800

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): BABY BOY Gerardo MARTINEZ		2. DATE OF DEATH (Month, Day, Year): AUGUST 13, 1989	3. TIME OF DEATH: 10:06 p.m
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS 2 / MIN.	7. DATE OF BIRTH (Month, Day, Year): 8 13 89 — 8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL	9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE CITY	9c. COUNTY OF DEATH: BALTIMORE	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Washington	10c. CITY, TOWN OR LOCATION: Hagerstown	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☐ NO
10e. STREET AND NUMBER: 349 Henry Avenue	10f. ZIP CODE: 21740	10g. CITIZEN OF WHAT COUNTRY?: usa	
11. MARITAL STATUS: Infant — 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☒ YES 2 ☐ NO Specify: Puerto Rican	14. RACE — American Indian, Black, White, etc. Specify: Puerto Rican
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 8+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Ernesto Morlaes Martinez	18. MOTHER'S NAME (First, Middle, Maiden Surname): Sharon Delores McNeil		
19a. INFORMANT'S NAME (Type/Print): Birth certif.	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): Hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): The Johns Hopkins Hospital	20c. LOCATION — City or Town, State: Balto., Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ N/A #47324 Bc	22. NAME AND ADDRESS OF FACILITY		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. SEVERE RESPIRATORY DISTRESS — DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. PROBABLE OVERWHELMING SEPSIS — DUE TO (OR AS A CONSEQUENCE OF):
c. — DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) — 28b. TIME OF INJURY — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Michelle Dundore, M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 8-13-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): MICHELLE DUNDORE M.D. JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.		
31. DATE FILED (Month, Day, Year): APR 18 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37801

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Alex Demetrius Hodge			2. DATE OF DEATH (Month, Day, Year): NOVEMBER 26, 1989	3. TIME OF DEATH: 7:16 P M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 0 YRS. IF UNDER 1 YEAR: MONTHS 0 DAYS 0 IF UNDER 24 HRS.: HOURS 1 MIN. 49	7. DATE OF BIRTH (Month, Day, Year): NOV. 26, 1990	8. BIRTHPLACE (State or Foreign Country): MD.
9a. FACILITY NAME (If not institution, give street and number): THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE		9c. COUNTY OF DEATH: BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE: MD.	10b. COUNTY: BALTIMORE CITY	10c. CITY, TOWN OR LOCATION: BALTIMORE, MARYLAND	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 2504 HERMOSA AVE		10f. ZIP CODE: 21214	10g. CITIZEN OF WHAT COUNTRY?: U.S.A.

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): N/A; College (1-4 or 5+): N/A	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NONE	16b. KIND OF SUSINESS/INDUSTRY: N/A	
17. FATHER'S NAME (First, Middle, Last): ALEXANDER HODGE		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY MURRAY	
19a. INFORMANT'S NAME (Type/Print): MARY MURRAY	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2504 HERMOSA AVE BALTIMORE, MD 21214		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): JOHNS HOPKINS DISPOSAL	20c. LOCATION — City or Town, State: BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: JOHNS HOPKINS DISPOSAL 600 n. WOLFE ST. 21205		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prematurity — 1hr 45min

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [X] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: M Carter MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 4/12/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mary E. Aitken 600 N. Wolfe St Baltimore MD		
31. DATE FILED (Month, Day, Year): MAY 07 '90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randolph	

DHMH-18 Rev 1/89

024929 MAR-9

FOR STATE REGISTRAR 89

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37803

1. DECEASED NAME (TYPE OR PRINT) — FIRST: Baby Boy — MIDDLE: — LAST: Smart

2a. DATE OF DEATH — MONTH: 1 — DAY: 6 — YEAR: 89

2b. HOUR: 9:20p M

3. SEX: Male

4. RACE: Black

5. DATE OF BIRTH — MONTH: 1 — DAY: 6 5 — YEAR: 89

6. AGE (IN YEARS LAST BIRTHDAY) YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?

8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH: Montgomery MD.

10. CITY OR TOWN OF DEATH: Silver Spring

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Holy Cross Hospital

12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)

12b. KIND OF BUSINESS OR INDUSTRY

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: D.C.

13b. COUNTY

13c. CITY OR TOWN: Washington

13d. INSIDE CITY LIMITS? YES ☒ NO ☐

13e. STREET ADDRESS: 249 Hamilton St., N.W., #2

14. FATHER'S NAME — FIRST: Lloyd — MIDDLE: — LAST: Smart

15. MOTHER'S MAIDEN NAME — FIRST: Hyacinth — MIDDLE: — LAST: Richards

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.

17. INFORMANT — ADDRESS: per birth certif. 5/30/90 kam

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity

765 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Immature Lung development

DUE TO, OR AS A CONSEQUENCE OF (c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES ☐ NO ☐

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY — HOUR A.M. P.M. — MONTH — DAY — YEAR 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)

21d. INJURY OCCURRED — WHILE AT WORK ☐ NOT WHILE AT WORK ☐

21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)

21f. LOCATION — STREET — CITY OR TOWN — COUNTY — STATE

22a. I certify that (I) (this hospital) attended the deceased from _____ 19____, to _____ 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE — DEGREE — ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☒ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT): Craig Dickman, M. D.

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)

23b. DATE

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION — CITY OR TOWN — COUNTY — STATE

24. FUNERAL DIRECTOR — NAME: Tyson Wheeler F H — ADDRESS: 1351 Rockville Pike, Rockville, Md

25a. DATE RECD. BY REGISTRAR: MAR 89

25b. REGISTRAR'S SIGNATURE

IMPORTANT. If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

BP_____

DHMH - 16 50M 1/81 (VRA 15, 4)

4

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37804

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Abbott, Male
2. DATE OF DEATH: MONTH 7 DAY 17 YEAR 89
3. TIME OF DEATH: 6:35 A M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☒ M 2 ☐ F
6. AGE (In yrs. last birthday): 0 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS 2 MIN. 4
7. DATE OF BIRTH (Month, Day, Year): 7-17-89
8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGES HOSPITAL CENTER
9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY
9c. COUNTY OF DEATH: PRINCE GEORGES

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: P G
10c. CITY, TOWN OR LOCATION: District Heights
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 2100 Tiber Dr.
10f. ZIP CODE: 20747
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: N/A — 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES: N/A
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify: N/A
14. RACE — American Indian, Black, White, etc. Specify: BLACK.
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): N/A — College (1-4 or 5+): N/A
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): N/A
16b. KIND OF BUSINESS/INDUSTRY: N/A.
17. FATHER'S NAME (First, Middle, Last): Charles Alexander Abbott III
18. MOTHER'S NAME (First, Middle, Maiden Surname): DANI V ABBOTT (Wilson)
19a. INFORMANT'S NAME (Type/Print): Mother - Davi V. Abbott
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2100 Tiber Dr. District Heights, Md. 20747
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☒ Other (Specify) Hospital
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC Cheverly, Md.
20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:
22. NAME AND ADDRESS OF FACILITY: PGHC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that ceused tha death. Do not anter tha moda of dying, such as cardiac or reapiratory arrest, ahock, or haert failure. List only ona cause on aach line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. NON VIABLE FETUS
DUE TO (OR AS A CONSEQUENCE OF):
b. NON VIABLE FETUS
DUE TO (OR AS A CONSEQUENCE OF):
c. NON VIABLE FETUS.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in tha underlying cause given in Part I.: N/A

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) N/A
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year): N/A
28b. TIME OF INJURY: N/A M
28c. INJURY AT WORK? N/A 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED: N/A.
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): N/A
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): N/A
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER:
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year): ▶ 7/17/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): DONNA MADURA PGHC CHEVERLEY MD
31. DATE FILED (Month, Day, Year): JUN 22 1990
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

D

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37805

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Male, MILLS				2. DATE OF DEATH: MONTH 6 DAY 10 YEAR 89		3. TIME OF DEATH: 12:01 AM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☑ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS 1 / MIN. 47	7. DATE OF BIRTH (Month, Day, Year): 6 9 89	8. BIRTHPLACE (State or Foreign Country): Maryland.
9a. FACILITY NAME (If not institution, give street and number): Prince George's Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly			9c. COUNTY OF DEATH: Prince George	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Suitland	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 5037 Suitland Rd.	10f. ZIP CODE: 20746		10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENOENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): not given		18. MOTHER'S NAME (First, Middle, Maiden Surname): Christine Mills
19a. INFORMANT'S NAME (Type/Print): med. record	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PGHC	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☑ Other (Specify) Hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Prematurity - 18-20 wks

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Avraham Kadar, M.D.	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 6/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): AVRAHAM KADAR, 325 CHARLES St. Rockville, Md. 20850		
31. DATE FILED (Month, Day, Year): JUN 22 1990	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37806

DIVISION OF VITAL RECORDS, P.O. BOX 13146, • BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Male Sanderson				2. DATE OF DEATH (Month, Day, Year): 08 24 89	3. TIME OF DEATH: 2 15 A M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 1 YRS. (IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. 30)		7. DATE OF BIRTH (Month, Day, Year): 08 24 89	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): P.G Hosp. Center.		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly MD		9c. COUNTY OF DEATH: P G.	
RESIDENCE OF DECEDENT					
10a. STATE: MD	10b. COUNTY: P G	10c. CITY, TOWN OR LOCATION: Hyattsville		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 3099 Nicholson St		10f. ZIP CODE: 20782		10g. CITIZEN OF WHAT COUNTRY? US	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☐ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): info not available		18. MOTHER'S NAME (First, Middle, Maiden Surname): Linda L. Sanderson			
19a. INFORMANT'S NAME (Type/Print): med. record		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PGHC			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) hospital		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC		20c. LOCATION — City or Town, State: Cheverly, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: X [signature]		22. NAME AND ADDRESS OF FACILITY: X PGHC			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Previable fetus 20 wks gestation	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] MD	D36993	▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1990	[signature]

DHMH-18 Rev 1/89

89-37807

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FEMALE DORSEY-BAILEY			2. DATE OF DEATH (Month, Day, Year): 5 17 89	3. TIME OF DEATH: 10:55 AM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☑ F	6. AGE (In yrs. last birthday): 0 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS 3, MIN. 15)	7. DATE OF BIRTH (Month, Day, Year): 5 17 89	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hosp. Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: P.G.	10c. CITY, TOWN OR LOCATION: Lanham	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 8108 Martin Luther King Jr. Hwy. Apt 713		10f. ZIP CODE: 20706	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Lawrence Sigmund Bailey	18. MOTHER'S NAME (First, Middle, Maiden Surname): Deborah Denise Dorsey	
19a. INFORMANT'S NAME (Type/Print): Deborah Dorsey	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 8108 Martin Luther King Jr. Hwy. Apt 713 Lanham 20706	
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ____	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. — Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Previable female infant
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☑ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? 1 ☐ YES 2 ☑ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Zenaida P. Alidon Prince Georges Hosp Cheverly MD

31. DATE FILED (Month, Day, Year): 5 JUN 22 1990	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89-37808

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Male Bullock			2. DATE OF DEATH (Month, Day, Year): 12 23 89	3. TIME OF DEATH: 230A M	
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS 0 DAYS 0 — IF UNDER 24 HRS.: HOURS 2 MIN. 40	7. DATE OF BIRTH (Month, Day, Year): 12-22-89	8. BIRTHPLACE (State or Foreign Country): Maryland	
9a. FACILITY NAME (If not institution, give street and number): PGHC		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: Prince Georges	
RESIDENCE OF DECEDENT					
10a. STATE: Md	10b. COUNTY: PG	10c. CITY, TOWN OR LOCATION: Lanham		10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 5646 Whitfield Chapel Rd. #202		10f. ZIP CODE: 20706		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5 +)	15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Euwon Chatman		18. MOTHER'S NAME (First, Middle, Maiden Surname): Pamela Katriva Bullock			
19a. INFORMANT'S NAME (Type/Print): Pamela Bullock		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5646 Whitfield Chapel Rd. #202 Lanham 20706			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anencephaly	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 5 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY M | 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
David Kaufman MD	033719	▶ 12/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1990	Gloria Davidson-Randall

DHMH-16 Rev 1/89

89-37809

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Girl Clark			2. DATE OF DEATH: MONTH 07 DAY 27 YEAR 89	3. TIME OF DEATH: 10:45 M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS; IF UNDER 24 HRS.: HOURS 7, MIN. 27	7. DATE OF BIRTH (Month, Day, Year): 07 27 89	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Prince George's Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly,	9c. COUNTY OF DEATH: Prince George's	
RESIDENCE OF DECEDENT				
10a. STATE: Md.	10b. COUNTY: PG	10c. CITY, TOWN OR LOCATION: Landover	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 2011 Barlowe Place		10f. ZIP CODE: 20785	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last): Jay Frances Wallace		18. MOTHER'S NAME (First, Middle, Maiden Surname): Melody Rachanda Clark		
19a. INFORMANT'S NAME (Type/Print): Melody Clark		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2011 Barlowe Place		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY: PGHC		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Extreme Prematurity
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined			1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	D 36014	▶ 7-27-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN KEITH M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1990	Julia Davidson-Randall

DHMH-18 Rev 1/89

89-37810

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Female Dilley	2. DATE OF DEATH: MONTH 4 DAY 19 YEAR 89	3. TIME OF DEATH: 6:48 PM	
4. SOCIAL SECURITY NUMBER: —	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS — DAYS — IF UNDER 24 HRS.: HOURS 2 MIN. —	7. DATE OF BIRTH (Month, Day, Year): 4/19/89 — 8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): PGHC	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: PG	

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Crofton	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 908 Eastham Ct #13	10f. ZIP CODE: 21114	10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) — College (1-4 or 5 +)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): John L. Dilly	18. MOTHER'S NAME (First, Middle, Maiden Surname): Colleen D. Carter		
19a. INFORMANT'S NAME (Type/Print): Colleen Dilly	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 908 Eastham Ct. #13 Crofton, Md. 21114		
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Colleen	22. NAME AND ADDRESS OF FACILITY: PGHC		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Non Viable Anencephalic Fetus

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. AS ABOVE

DUE TO (OR AS A CONSEQUENCE OF):

c. AS ABOVE.

DUE TO (OR AS A CONSEQUENCE OF):

d. AS ABOVE.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

NONE

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A — 28b. TIME OF INJURY: N/A M — 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO — 28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Osmanmadueke	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year): ▶ 4/19/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): OBI MADUKA, PGHC		
31. DATE FILED (Month, Day, Year): JUN 22 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DHMH-16 Rev 1/89

89-37811

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Freeman
2. DATE OF DEATH — MONTH: 8 DAY: 4 YEAR: 89
3. TIME OF DEATH: 5:40 AM
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: 2 MIN.: —
7. DATE OF BIRTH (Month, Day, Year): 8 4 89
8. BIRTHPLACE (State or Foreign Country): Prince George's
9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY
9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE: Maryland
10b. COUNTY: Prince George
10c. CITY, TOWN OR LOCATION: Landover Hills
10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 4803 68th Ave.
10f. ZIP CODE: 20784
10g. CITIZEN OF WHAT COUNTRY? Liberia
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Charles Eugene Freeman
18. MOTHER'S NAME (First, Middle, Maiden Surname): Santa Amelia Williams
19a. INFORMANT'S NAME (Type/Print): Santa Freeman
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4803 68th Ave. Landover Hills, Md. 20784
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) Hospital
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC
20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]
22. NAME AND ADDRESS OF FACILITY: PGHC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Previable infant — DUE TO (OR AS A CONSEQUENCE OF): — 2 hours

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 8 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: Abraham Kanla MD
29c. LICENSE NUMBER:
29d. DATE SIGNED (Month, Day, Year) ▶ 8-4-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Abraham Kanlaowsky
31. DATE FILED (Month, Day, Year): 8 JUN 22 1990
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Kendall

DHMH-18 Rev 1/89

89-37812

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Jessica Goodwine			2. DATE OF DEATH (Month / Day / Year): 5 / 27 / 89	3. TIME OF DEATH: 2:30 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 17 / MIN. 30	7. DATE OF BIRTH (Month, Day, Year): 5/26/89	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): PGHC		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: PG	10c. CITY, TOWN OR LOCATION: Bladensburg	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 4269 58th Ave #N		10f. ZIP CODE: 20710	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Stuart Kerwin Goodwine	16. MOTHER'S NAME (First, Middle, Maiden Surname): Joyce Renee Cutchember	
18a. INFORMANT'S NAME (Type/Print): Joyce Goodwine	18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4269 58th Ave. #N Bladensburg, Ma. 20710	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Congenital Heart Defect (complex)	17 H
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Trisomy 13	17 H
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: multiple congenital anomalies

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D36993	29d. DATE SIGNED (Month, Day, Year): 5/27/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Alejandro L. Soriano MD, Dept. of Pediatrics, PGH, Cheverly, MD

31. DATE FILED (Month, Day, Year): JUN 22 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DNMN-16 Rev 1/89

89-37813

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby girl Horton
2. DATE OF DEATH — MONTH: 4 DAY: 10 YEAR: 89
3. TIME OF DEATH: 9:35 AM
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR — MONTHS: DAYS: IF UNDER 24 HRS. — HOURS: 2 MIN.: 45
7. DATE OF BIRTH (Month, Day, Year): 4/10/89
8. BIRTHPLACE (State or Foreign Country): MD
8a. FACILITY NAME (If not institution, give street and number): PGHC
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: PG

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: Forestville
10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 3309 Walters Ln T-2
10f. ZIP CODE: 20747
10g. CITIZEN OF WHAT COUNTRY?: USA
11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEOENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): College (1-4 or 5+):
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Kevin Norman Johnson
18. MOTHER'S NAME (First, Middle, Maiden Surname): Denise Horton
19a. INFORMANT'S NAME (Type/Print): Denise Horton
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3309 Walters Ln T-2 Forestville, Md. 20747
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) hospital
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC
20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE:
22. NAME AND ADDRESS OF FACILITY: PGHC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiorespiratory failure
DUE TO (OR AS A CONSEQUENCE OF):
b. Previable infant
DUE TO (OR AS A CONSEQUENCE OF):
c. Severe immaturity

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF OEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. OESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER:
29d. DATE SIONEO (Month, Day, Year): 4/10/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETEO CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): JUN 27 1990
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

89-37814

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Boy Hamilton				2. DATE OF DEATH: MONTH 9 DAY 2 YEAR 89	3. TIME OF DEATH: 2:30 P M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 0 YRS.	IF UNDER 1 YEAR: MONTHS 0 DAYS 0 / IF UNDER 24 HRS.: HOURS 2 MIN. 16	7. DATE OF BIRTH (Month, Day, Year): 9 2 89	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): PGHC		9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: PG	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: PG	10c. CITY, TOWN OR LOCATION: Landover	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 1109 Capt VW Dr 533		10f. ZIP CODE: 20785	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): not known	18. MOTHER'S NAME (First, Middle, Maiden Surname): Pamela Hamilton
19a. INFORMANT'S NAME (Type/Print): med. record	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PGHC

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify): hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Extreme Prematurity
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature]	29c. LICENSE NUMBER: D36014	29d. DATE SIGNED (Month, Day, Year): 5-2-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): STEPHEN KEITH M.D.

31. DATE FILED (Month, Day, Year): JUN 22 1990	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-18 Rev 1/89

89-37815

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Martin Baby Boy
2. DATE OF DEATH: Month 6 Day 17 Year 89
3. TIME OF DEATH: 5:12 A M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 ☑ M 2 ☐ F
6. AGE (In yrs. last birthday) YRS.: IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours 1 Min. 47
7. DATE OF BIRTH (Month, Day, Year): 6 17 89
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): P.G.G.H.
9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly
9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: Md.
10b. COUNTY: P.G.
10c. CITY, TOWN OR LOCATION: Suitland
10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: ~~38~~ 3908 Regency Parkway #304
10f. ZIP CODE: 20746
10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Not known
18. MOTHER'S NAME (First, Middle, Maiden Surname): Yvette Martin
19a. INFORMANT'S NAME (Type/Print): medical record
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PGHC
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) ~~hospital~~
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC
20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶
22. NAME AND ADDRESS OF FACILITY: PGHC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardiopulmonary Arrest
DUE TO (OR AS A CONSEQUENCE OF):
b. Extreme Prematurity
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: MD
29c. LICENSE NUMBER
29d. DATE SIGNED (Month, Day, Year) ▶ 6 17 89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
31. DATE FILED (Month, Day, Year): JUN 22 1990
32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

89-37816

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH (Month / Day / Year)	3. TIME OF DEATH
MEADOWS		08 / 18 / 89	12 50AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
	1 ☒ M 2 ☐ F	NB/day YRS.	0 / 0	0 / 21	8-18-89	Maryland

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
PRINCE GEORGE'S HOSPITAL CENTER	CHEVERLY	PRINCE GEORGE'S

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	Prince Georges	Landover	1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
6608 West Forest Rd 101	20785	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☒ NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Not known	Katrine S. Meadows

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
med record	PGHC

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) PGHC hospital	PGHC	Cheverly, Md.

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ [signature]	PGHC

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Immature, Non Viable 16-18 weeks

DUE TO (OR AS A CONSEQUENCE OF):
b. Male Infant.

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

DUE TO (OR AS A CONSEQUENCE OF):
c.

DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☐ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☒ NO	HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Krishan Gulati.	D38308.	▶ 8/18/89.

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
KRISHAN GULATI, P.G Hospital, Cheverly MD-20785.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 22 1990	[signature]

DHMH-18 Rev 1/89

89-37817

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 & 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Bb girl Parsley twin A			2. DATE OF DEATH (Month / Day / Year): 7 / 19 / 89	3. TIME OF DEATH: 2:07 P M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. One hour	7. DATE OF BIRTH (Month, Day, Year): 7/19/89	8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Prince Georges Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly		9c. COUNTY OF DEATH: PG	
RESIDENCE OF DECEDENT				
10a. STATE: MD	10b. COUNTY: PG	10c. CITY, TOWN OR LOCATION: Beltsville	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 4723 Quimby Ave.	10f. ZIP CODE: 20705	10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last): William Lee Parsley	18. MOTHER'S NAME (First, Middle, Maiden Surname): Marian Parsley (Marda)			
19a. INFORMANT'S NAME (Type/Print): Marion Parsley	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4723 Quimby Ave. Beltsville, Md. 20705			
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Dimensional Health (hospital)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Anencephaly	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Borderline prematurity	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)

28b. TIME OF INJURY M

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
[signature] Alidon M.D.		▶ 7/19/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Zenaida P. Alidon M.D.

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
JUN 26 1990	[signature] Davidson Randall

DHMH-16 Rev 1/89

89-37818

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): FEMALE SMITH					2. DATE OF DEATH: MONTH 8 DAY 12 YEAR 89	3. TIME OF DEATH: 3.30 PM M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR: MONTHS	DAYS	IF UNDER 24 HRS.: HOURS 1 MIN. 22	7. DATE OF BIRTH (Month, Day, Year): 8-12-89
8. BIRTHPLACE (State or Foreign Country): MD						

9a. FACILITY NAME (If not institution, give street and number): PRINCE GEORGE'S HOSPITAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: CHEVERLY	9c. COUNTY OF DEATH: P.G.

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Prince Georges	10c. CITY, TOWN OR LOCATION: Laurel	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 12925 Bowie Rd #203		10f. ZIP CODE: 20707	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Not known	18. MOTHER'S NAME (First, Middle, Maiden Surname): Elizabeth C. Smith
19a. INFORMANT'S NAME (Type/Print): Elizabeth C. Smith	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 12925 Bowie Rd #203 Laurel, Md 20707

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) _____	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART i. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Immature 20-22 wks Non-Viable	1 Hour & 28 Minutes
DUE TO (OR AS A CONSEQUENCE OF):	Female Infant.	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Chorio amnotis.	
DUE TO (OR AS A CONSEQUENCE OF):		
	c.	
DUE TO (OR AS A CONSEQUENCE OF):		
	d.	

PART ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☒ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): N/A	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Krishan Gulati M.D	29c. LICENSE NUMBER: D38308	29d. DATE SIGNED (Month, Day, Year): ▶ 8 12 89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KRISHAN K. GULATI, PG Hospital, Cheverly, MD - 20785

31. DATE FILED (Month, Day, Year): JUN 22 1990	32. REGISTRAR'S SIGNATURE: [signature]

DHMH-16 Rev 1/89

89-3789

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TAYLOR "A"			2. DATE OF DEATH MONTH 11 DAY 23 YEAR 89	3. TIME OF DEATH 5:20 PM
4. SOCIAL SECURITY NUMBER	5. SEX 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday) 0 YRS. — IF UNDER 1 YEAR: MONTHS 0 DAYS; IF UNDER 24 HRS.: HOURS 2 MIN.	7. DATE OF BIRTH (Month, Day, Year) 11-23-88	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Prince George Hosp. Ctr		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly, MARYLAND		9c. COUNTY OF DEATH Prince Geo

RESIDENCE OF DECEDENT

10a. STATE D.C. ~~Md.~~	10b. COUNTY	10c. CITY, TOWN OR LOCATION Washington DC	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER 30 Varnum St NE		10f. ZIP CODE 20011	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): not given	18. MOTHER'S NAME (First, Middle, Maiden Surname): Monica E Taylor	
19a. INFORMANT'S NAME (Type/Print): med. record	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PGHC	

20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio-Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Extreme prematurity
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Chelsea Kakowska	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 11/24/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1142 Kersey Rd Silver Spring Maryland

31. DATE FILED (Month, Day, Year) JUN 22 1990	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

DHMH-16 Rev 1/89

89-37820

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): TAYLOR "Bill"			2. DATE OF DEATH — MONTH: 11-23 DAY: 89 YEAR	3. TIME OF DEATH: ~5:00 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS: 2 / MIN.	7. DATE OF BIRTH (Month, Day, Year): 11-23-89	8. BIRTHPLACE (State or Foreign Country): Prince Georges

9a. FACILITY NAME (If not institution, give street and number): Prince Georg Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly Maryland	9c. COUNTY OF DEATH: Prince Georges

RESIDENCE OF DECEDENT

10a. STATE: DC	10b. COUNTY: —	10c. CITY, TOWN OR LOCATION: Washington DC	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: 30 Varnum St NE		10f. ZIP CODE: 20011	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): Not given	18. MOTHER'S NAME (First, Middle, Maiden Surname): Monica E. Taylor
19a. INFORMANT'S NAME (Type/Print): med. record	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): PGHC

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) hospital	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PGHC	20c. LOCATION — City or Town, State: Cheverly, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ [signature]	22. NAME AND ADDRESS OF FACILITY: PGHC	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cardio Respiratory Arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. severe premature	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 8 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 11-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): 1142 Kersey Road Silver Spring Maryland		
31. DATE FILED (Month, Day, Year): JUN 22 1990	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall	

DNMH-16 Rev 1/89

Orig. lost in DVR, per Kam 8/7/90

89-37821

1989

1 - FOR STATE REGISTRAR

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37822

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): NO NAME SUBMITTED (Twin A) Jenkins			2. DATE OF DEATH (Month, Day, Year): May 2, 1989	3. TIME OF DEATH: 10:30P M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN. 20	7. DATE OF BIRTH (Month, Day, Year): May 2, 1989	8. BIRTHPLACE (State or Foreign Country): Montgomery
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville	9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 507 North Horners Lane		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12); College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Bernard Lane Jenkins, Jr.		18. MOTHER'S NAME (First, Middle, Maiden Surname): Beth Diane Weiss	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shady Grove Adventist	20c. LOCATION — City or Town, State: Rockville
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶		22. NAME AND ADDRESS OF FACILITY	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Gross immaturity – nonviable by current standards
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M / 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO / 28d. DESCRIBE HOW INJURY OCCURED	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel Matathias - Gen Pediatrician	29c. LICENSE NUMBER: D35124	29d. DATE SIGNED (Month, Day, Year) ▶ 5/10/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Daniel Matathias 9314 Cherry Hill Rd #725 College Pk, MD 20740

31. DATE FILED (Month, Day, Year): JUN 1 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37823

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Twin Boy B Jenkins			2. DATE OF DEATH: MONTH 5 DAY 2 YEAR 89	3. TIME OF DEATH: 2245 M	
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): <1hr Yrs. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. 35	7. DATE OF BIRTH (Month, Day, Year): 5/2/89	8. BIRTHPLACE (State or Foreign Country): Maryland Montgomery	
9a. FACILITY NAME (If not institution, give street and number): Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Rockville, Md.		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Rockville	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 507 North Horners Lane		10f. ZIP CODE: 20850	10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Bernard Lane Jenkins, Jr.	18. MOTHER'S NAME (First, Middle, Maiden Surname): Beth Diane Weiss	
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	

20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Shady Grove Adventist	20c. LOCATION — City or Town, State: Rockville
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Immature, non-viable fetus — 35 min

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.
Premature onset of labor

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Daniel Matathias (House Pediatrician)	29c. LICENSE NUMBER: D35124	29d. DATE SIGNED (Month, Day, Year) ▶ 5/2/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
Daniel Matathias 9314 Cherry Hill Rd #725 College Park, Md. 20740

31. DATE FILED (Month, Day, Year) JUN 1 90	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

BIRTH #68723

90-37824

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Boy Mielke
2. DATE OF DEATH: MONTH 9 DAY 14 YEAR 89
3. TIME OF DEATH: 3:55 (P) M
4. SOCIAL SECURITY NUMBER:
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): YRS.
IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN. 28
7. DATE OF BIRTH (Month, Day, Year): 9 14 89
8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): Univ. of Maryland Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City
9c. COUNTY OF DEATH: Baltimore City

RESIDENCE OF DECEDENT

10a. STATE
10b. COUNTY
10c. CITY, TOWN OR LOCATION
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER
10f. ZIP CODE
10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO
IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify:

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12); College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last): DAVID CHARLES MIELKE
18. MOTHER'S NAME (First, Middle, Maiden Surname): ADRIENNE MARIE FARREN

19a. INFORMANT'S NAME (Type/Print)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)

20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) in-state removal
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)
20c. LOCATION — City or Town, State

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Tommy L Wade 7-31-90
22. NAME AND ADDRESS OF FACILITY: State Anatomy Board, Balto., Md.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Non-Viable premature infant
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b.
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO
26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA
OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Iyad Aljabi, MD
29c. LICENSE NUMBER: D37413
29d. DATE SIGNED (Month, Day, Year): 9/14/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): IYAD ALJABI, M.D. UNIV. of MD Hospital

31. DATE FILED (Month, Day, Year): AUG 6 1990
32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 90-37825

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, ___ filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): LILLIE MAE Smith					2. DATE OF DEATH (Month, Day, Year): Dec 17 1989	3. TIME OF DEATH: 1410 M
4. SOCIAL SECURITY NUMBER: 245-62-7839	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 47 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 7-11-43	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO	
RESIDENCE OF DECEDENT						
10a. STATE: Md	10b. COUNTY: Wicomico	10c. CITY, TOWN OR LOCATION: Willards			10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO	
10e. STREET AND NUMBER: 4 East Holland Ave		10f. ZIP CODE: 21874			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Blk	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8 / College (1-4 or 5+): —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Disabled			16b. KIND OF BUSINESS/INDUSTRY: —	
17. FATHER'S NAME (First, Middle, Last): Curly Smith					18. MOTHER'S NAME (First, Middle, Maiden Surname): Ava Peick Smith	
19a. INFORMANT'S NAME (Type/Print): Estella McNeal		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 4 East Holland Ave Willards md 21874				
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Family Cemetery			20c. LOCATION — City or Town, State: Snow Hill md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: [signature]		22. NAME AND ADDRESS OF FACILITY: Lok 7/11 Salisbury md.				

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Respiratory Failure	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. End stage Primary pulmonary hypertension	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Probable recurrent pulmonary embolic	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Cor Pulmonale

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Charles Rad m.d.	D19289	▶ 12/18/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Charles L. Rad m.d. PO Box 2636 Salisbury MD 21801

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
AUG 08 1990	Julia Davidson-Randall

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37826

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be removed by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 must be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~BOY CHARLENE BURGESS~~ Cedric Cornell Easter, Jr.	2. DATE OF DEATH (Month / Day / Year): 03 / 23 / 89	3. TIME OF DEATH: 4:10 pm M	
4. SOCIAL SECURITY NUMBER: N/A	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 0 YRS. — IF UNDER 1 YEAR: MONTHS 0, DAYS 0 — IF UNDER 24 HRS.: HOURS 15, MIN. 45	7. DATE OF BIRTH (Month, Day, Year): 03/23/89 — 8. BIRTHPLACE (State or Foreign Country): MARYLAND
9a. FACILITY NAME (If not institution, give street and number): GREATER BALTIMORE MEDICAL CENTER	9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON	9c. COUNTY OF DEATH: BALTIMORE COUNTY	
RESIDENCE OF DECEDENT			
10a. STATE: MD	10b. COUNTY:	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [ ] NO
10e. STREET AND NUMBER: 4414 FALLS BRIDGE DR, BALTIMORE	10f. ZIP CODE: 21211	10g. CITIZEN OF WHAT COUNTRY?: U.S.	
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [ ] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12): — College (1-4 or 8+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Cedric Cornell Easter	18. MOTHER'S NAME (First, Middle, Maiden Surname): CHARLENE CECELIA BURGESS		
19a. INFORMANT'S NAME (Type/Print):	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code):		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [X] Other (Specify) ~~hospital~~	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): GBMC	20c. LOCATION — City or Town, State: Towson, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ▶	22. NAME AND ADDRESS OF FACILITY: GBMC		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. CARDIOPULMONARY ARREST — DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. EXTRME PREMATURITY — DUE TO (OR AS A CONSEQUENCE OF):	
	c. INTRAVENTRICULAR HEMORRHAGE GRADES III & IV — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 8 [ ] Pending Investigation 8 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: [signature] MD	29c. LICENSE NUMBER: D-22434	29d. DATE SIGNED (Month, Day, Year) ▶ 8/9/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print):		
31. DATE FILED (Month, Day, Year): AUG 14 1990	32. REGISTRAR'S SIGNATURE: [signature]	

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37827

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): RALPH WILLIAM LANE				2. DATE OF DEATH: MONTH December DAY 26 YEAR 1989	3. TIME OF DEATH: 9:50 A M
4. SOCIAL SECURITY NUMBER: 232-07-0133	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 78 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): April 11, 1911	8. BIRTHPLACE (State or Foreign Country): W. Va.
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Oakland		9c. COUNTY OF DEATH: Garrett

RESIDENCE OF DECEDENT

10a. STATE: W. Va.	10b. COUNTY: Grant	10c. CITY, TOWN OR LOCATION: Mt. Storm	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER: General Delivery		10f. ZIP CODE: 26739	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 [ ] Never Married 2 [ ] Married 3 [X] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): Unknown; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Machinist	16b. KIND OF BUSINESS/INDUSTRY: Goodyear Tire & Rubber	
17. FATHER'S NAME (First, Middle, Last): Jason W. Lane		18. MOTHER'S NAME (First, Middle, Maiden Surname): Mary Regger	
19a. INFORMANT'S NAME (Type/Print): Beverly Bennett	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): General Delivery - Mt. Storm, W. Va. 26739		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Mt. State Memorial Gardens	20c. LOCATION — City or Town, State: Elkins, W. Va.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert H Durst M00167	22. NAME AND ADDRESS OF FACILITY: P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	Intracerebral Bleed	12 hr.
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	Acute Hypoxia	24 hr.
DUE TO (OR AS A CONSEQUENCE OF):		
c.	Acute Upper Respiratory Obstruction with foreign body	24 hr.
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [ ] YES 2 [X] NO	1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)			
27. MANNER OF DEATH: 1 [ ] Natural 2 [X] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12/25/89	28b. TIME OF INJURY: 2 P M	28c. INJURY AT WORK? 1 [ ] YES 2 [X] NO	28d. DESCRIBE HOW INJURY OCCURED: Choked on piece of meat
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): P.O. Box #1 Mt. Storm, W. Va.

29a. CERTIFIER (Check only one)
1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Karl F Schwalm MD	29c. LICENSE NUMBER: D27205	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KARL F. SCHWALM OAKLAND, MD 21550

31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: Gloria Davidson Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37828

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Olive Aleen MALPUSS				2. DATE OF DEATH (Month, Day, Year): December 28, 1989	3. TIME OF DEATH: 735 P M
4. SOCIAL SECURITY NUMBER: 439-20-4599	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 85 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Aug. 22, 1904	8. BIRTHPLACE (State or Foreign Country): Arkansas
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Oakland		9c. COUNTY OF DEATH: Garrett

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Oakland	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: Rt. 1, Box 6-B		10f. ZIP CODE: 21550	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 6th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Operator(Telephone)	16b. KIND OF BUSINESS/INDUSTRY: Ford Dealership	
17. FATHER'S NAME (First, Middle, Last): Samuel ----- Ware		18. MOTHER'S NAME (First, Middle, Maiden Surname): Olive ----- (Unknown)	
19a. INFORMANT'S NAME (Type/Print): Mrs. Dorothy E. Pennoyer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 3001 Brock Drive, Upper Marlboro, MD 20772	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Cedar Hill Cemetery	20c. LOCATION — City or Town, State: Suitland, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart		22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 South Second St., Oakland, MD 21550	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ~~AA~~ sepsis — DUE TO (OR AS A CONSEQUENCE OF):	2days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. urinary tract infection — DUE TO (OR AS A CONSEQUENCE OF):	
	c. pneumonia — DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

hypertensive
diabetes
breast cancer

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☒ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA; OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO	28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one): 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Margaret Kaiser MD	29c. LICENSE NUMBER: D26650	29d. DATE SIGNED (Month, Day, Year): ▶ 12/29/89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Dr. Margaret Kaiser, MD U.S. Rt. 219-North, Oakland, Maryland 21550

31. DATE FILED (Month, Day, Year): DEC 29 '89	32. REGISTRAR'S SIGNATURE: Gloria Davidson-Randall

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37829

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages [illegible] should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Reland Adair ROY			2. DATE OF DEATH (Month, Day, Year): December 25, 1989	3. TIME OF DEATH: 4:47 a. M
4. SOCIAL SECURITY NUMBER: 218-26-8531	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 60 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN.)	7. DATE OF BIRTH (Month, Day, Year): Sept. 4, 1929	8. BIRTHPLACE (State or Foreign Country): West Virginia
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Oakland	9c. COUNTY OF DEATH: Garrett	
RESIDENCE OF DECEDENT				
10a. STATE: Maryland	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Oakland	10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO	
10e. STREET AND NUMBER: Rt. 5 Box 99		10f. ZIP CODE: 21550	10g. CITIZEN OF WHAT COUNTRY?: USA	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 8th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Mechanic	16b. KIND OF BUSINESS/INDUSTRY: Coal Mining		
17. FATHER'S NAME (First, Middle, Last): Edison Riley Roy	18. MOTHER'S NAME (First, Middle, Maiden Surname): Hazel Alice Markley			
19a. INFORMANT'S NAME (Type/Print): Opal G. Roy	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 5 Box 99 Oakland, Maryland 21550			
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Oakland Cemetery	20c. LOCATION — City or Town, State: Oakland, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Franklin H. Custer	22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home 32 South Second Street Oakland, MD 21550			

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Pneumonia	2-3 days
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): Squamous cell CA lung	X 9-12 Mo
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d. DUE TO (OR AS A CONSEQUENCE OF):	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: COPD/pneumoconiosis

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)		
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	

29a. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: T Holum MD	29c. LICENSE NUMBER: D15333	29d. DATE SIGNED (Month, Day, Year): ▶ 12/26/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Thomas G. Johnson, MD 311 N 4th Street Oakland, Maryland 21550		
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37830

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): WILLA MARGARET SPEICHER				2. DATE OF DEATH (Month, Day, Year): December 27 1989	3. TIME OF DEATH: 6:34 AM
4. SOCIAL SECURITY NUMBER: 217-30-1698	5. SEX: 1 ☐ M 2 ☒ F	6. AGE (In yrs. last birthday): 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Nov 12, 1912	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH: Oakland		9c. COUNTY OF DEATH: Garrett

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Garrett	10c. CITY, TOWN OR LOCATION: Oakland	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 6 Box 65		10f. ZIP CODE: 21550	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12)	College (1-4 or 5+): 2	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Homemaker	16b. KIND OF BUSINESS/INDUSTRY: Own Home
17. FATHER'S NAME (First, Middle, Last): Thomas Edward Harvey		18. MOTHER'S NAME (First, Middle, Maiden Surname): Elva Jane Sharpless	
19a. INFORMANT'S NAME (Type/Print): Mrs. Linda Harr		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 4 Box 156 Deer Park, Md. 21550	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Deer Park Cemetery	20c. LOCATION — City or Town, State: Deer Park, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Robert M Durst M00167		22. NAME AND ADDRESS OF FACILITY: P.O. Box 243 Durst Funeral Home - Oakland, Md. 21550	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acute cardiopulmonary arrest	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. Cardiovascular disease	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c. Diabetes mellitus	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Severe peripheral vascular disease

	24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☑ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☑ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURED
			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☑ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Donald R Richter MD	29c. LICENSE NUMBER: D30035	29d. DATE SIGNED (Month, Day, Year): ▶ 12/27/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Donald R. Richter, M.D. Oakland, Maryland 21550		
31. DATE FILED (Month, Day, Year): DEC 28 '89	32. REGISTRAR'S SIGNATURE: [illegible]	

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1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37831

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Eric Clayton Stemple			2. DATE OF DEATH (Month, Day, Year): 12-23-89	3. TIME OF DEATH: 11:55PM M
4. SOCIAL SECURITY NUMBER: 232-92-5491	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): 31 YRS. — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): Feb. 13, 1958	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Garrett County Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Oakland	9c. COUNTY OF DEATH: Garrett County	

RESIDENCE OF DECEDENT

10a. STATE: West Va.	10b. COUNTY: Preston	10c. CITY, TOWN OR LOCATION: St. George	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: Rt. 2 Box 211		10f. ZIP CODE: 26290	10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12th; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Plumber	16b. KIND OF BUSINESS/INDUSTRY: Plumbing Contractor	
17. FATHER'S NAME (First, Middle, Last): Frederick Holmes Stemple		18. MOTHER'S NAME (First, Middle, Maiden Surname): Thelma Jean Wiles	
19a. INFORMANT'S NAME (Type/Print): Clara L. Stemple		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 2 Box 211 St. George, West Virginia 26290	
20a. METHOD OF DISPOSITION: 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): Aurora Cemetery	20c. LOCATION — City or Town, State: Aurora, West Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Bradley A. Stewart		22. NAME AND ADDRESS OF FACILITY: Stewart Funeral Home, 32 South Second Street Oakland, MD 21550	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
☒ YES 2 ☐ NO	☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? ☒ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient ☒ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)	
27. MANNER OF DEATH: 1 ☐ Natural ☒ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 12-23-89	28b. TIME OF INJURY: 10:30PM	28c. INJURY AT WORK? 1 ☐ YES 2 ☒ NO
	28d. DESCRIBE HOW INJURY OCCURED: Driver in auto/auto impact		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): MD Rt. 560/S.of White Church Rd. Garrett County, Maryland	

29a. CERTIFIER (Check only one): 1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 12-24-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, MD	111 Penn Street, Baltimore, Md 21201	vc
31. DATE FILED (Month, Day, Year): DEC 27 '89	32. REGISTRAR'S SIGNATURE: Julia Davidson Randall	

5

DHMH-16 Rev 1/89

UNKNOWN 89-94

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37832

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ... after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Julian Carlyle Jenkins				2. DATE OF DEATH (Month, Day, Year): 7-6-89	3. TIME OF DEATH: 9:50AM M
4. SOCIAL SECURITY NUMBER: 215-38-6651	5. SEX: 1 ☐ M 2 ☐ F — X	6. AGE (In yrs. last birthday): 52 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 08-03-37	8. BIRTHPLACE (State or Foreign Country):
9a. FACILITY NAME (If not institution, give street and number): Loft area of Old Barn, ¼ mi. W.of Byron Tannery			9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH: Washington County	

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Hagerstown	10c. CITY, TOWN OR LOCATION: Washington Co.	10d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO
10e. STREET AND NUMBER: 16 S. Locust Street		10f. ZIP CODE:	10g. CITIZEN OF WHAT COUNTRY?

11. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced — X	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO. IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify: ~~White~~	14. RACE — American Indian, Black, White, etc. Specify: White

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last):		18. MOTHER'S NAME (First, Middle, Maiden Surname):	
19a. INFORMANT'S NAME (Type/Print): Barbara Jenkins		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 13372 SW. 255 Terrace, Priceton, Fla.	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) X in-state rem.		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): State Anatomy Board	20c. LOCATION — City or Town, State: Balto. Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: Donald M. Wade 8/20/89		22. NAME AND ADDRESS OF FACILITY	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. No anatomic cause of death	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? XXX YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? XXX YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? XXX YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence XXX Other (Specify) Scene	
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☒ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and menner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Julia C. Goodin M.D.	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): 7-7-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Julia C. Goodin, M.D.	111 Penn Street, Baltimore, MD 21201	VC
31. DATE FILED (Month, Day, Year): SEP 05 1990	32. REGISTRAR'S SIGNATURE: L. Lavalon-Reynolds	

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO 89-37833

HOUR

EDNA MERLE SISLER FEBRUARY 27, 1987 1:45P M

ale | White | 69

Virginia

BALTIMORE CITY OR COUNTY OF DEATH: ALLEGANY COUNTY MD.

HEART HOSPITAL

Own Home

Garrett

276 21531

Myrtle Reckart

#13 above

Arch of Medical Parts

AND MD 21

MD

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

Orig. lost in DVR this from L.H.D. 10/17/90 kam

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 16 50M 1/81
(VRA 15, 4)

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37834

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): William ~~EMPROSO~~ Peter Emproso		2. DATE OF DEATH (Month, Day, Year): March 13, 1989	3. TIME OF DEATH: 5:26p
4. SOCIAL SECURITY NUMBER: 575-32-1850	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday): 54 YRS. (If under 1 year: Months, Days; If under 24 hrs.: Hours, Min.)	7. DATE OF BIRTH (Month, Day, Year): 5 18 35
8. BIRTHPLACE (State or Foreign Country): Hawaii			
9a. FACILITY NAME (If not institution, give street and number): Franklin Square Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Rosedale	9c. COUNTY OF DEATH: Baltimore County	
RESIDENCE OF DECEDENT			
10a. STATE: Maryland	10b. COUNTY: Baltimore	10c. CITY, TOWN OR LOCATION: Baltimore	10d. INSIDE CITY LIMITS? 1 [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 5934 Schering Road	10f. ZIP CODE: 21206	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [X] YES 2 [ ] NO. IF YES, GIVE WAR OR DATES: Vietnam	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Filipino
15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 years; College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Enlisted	16b. KIND OF BUSINESS/INDUSTRY: U.S. Army	
17. FATHER'S NAME (First, Middle, Last): Emidio Emproso	18. MOTHER'S NAME (First, Middle, Maiden Surname): Balassa Barbadillo		
19a. INFORMANT'S NAME (Type/Print): Marie Ann Emproso	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5934 Schering Rd., Baltimore, Md. 21206		
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): St. James UNion Cemetery	20c. LOCATION — City or Town, State: Havre de Grace, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Edward M. Carey	22. NAME AND ADDRESS OF FACILITY: Tarring Funeral HOme, P.A. 333 S. Parke St., Aberdeen, Md. 21001-3399		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. RESPIRATORY ARREST	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. METASTATIC ADENOCARCINOMA OF LUNG	14 MOS
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [X] NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 [ ] Inpatient 2 [X] ER/Outpatient 3 [ ] DOA; OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined

28a. DATE OF INJURY (Month, Day, Year) | 28b. TIME OF INJURY | 28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO | 28d. DESCRIBE HOW INJURY OCCURED

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) | 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

28g. CERTIFIER (Check only one): 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

28h. SIGNATURE AND TITLE OF CERTIFIER	28c. LICENSE NUMBER: D35606	28d. DATE SIGNED (Month, Day, Year): ▶ 3/14/89

29. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Sam Ziegler, M.D. 3100 Wyman Park Dr., Balto., 21211

31. DATE FILED (Month, Day, Year): 3.16.89	32. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

DHMH-16 Rev 1/89

UNKNOWN 90- 3 A & B

ITEMS:2,3,28a,28e per ME
G-669 11-2-90 cm

89-37835

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH (Month, Day, Year)	3. TIME OF DEATH
Edward	(NMN)	McBride	~~1-17-90~~ 10/7/89	~~10:17 AM~~ M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
096-32-2590	1 [X] M 2 [ ] F	48 YRS.			4 25 41	Illinois

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
2511 Madison Avenue-rear 21217	Baltimore City	-------

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	-------	Baltimore	1 [ ] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
2034 Madison Avenue	21217	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [X] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	1 [ ] YES 2 [X] NO Specify:	Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5+)		
	4 yrs	Salesman	Computers

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
Eddie McBride	Marie Langston

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Margaret E. McBride	2034 Madison Avenue, Balto., MD 21217

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	Metro Crematory, Inc.	Baltimore, MD

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ George E. MacNabb	Cremation Society of Maryland Baltimore, Maryland 21228

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Multiple stab wounds	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
XX 1 [ ] YES 2 [ ] NO	XXX 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
XX [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence XX [X] Other (Specify) SCENE

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide XXX [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined	~~Ukn.~~ 10/7/89	Ukn. M	1 [ ] YES XXX [X] NO	Subject stabbed

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
~~Rear~~ APARTMENT BUILDING	2511 Madison Avenue, Baltimore, MD

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
XXX 2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
	OCME	▶ 1-18-90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
FRANK PERETTI, MD 111 Penn Street, Baltimore, MD 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
FEB 08 1990	

DHMH-16 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

ITEMS:23pt1 thru 28f per ME
G-673 3/22/91 cm

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37836

3

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEOENT'S NAME (First, Middle, Last)		2. DATE OF DEATN (Month / Day / Year)	3. TIME OF DEATN
Ralph	Morgan	3-30-89	10:50AM M

4. SOCIAL SECURITY NUMBER	5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTN (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-70-4870	1 [X] M 2 [ ] F	29 YRS.			01-11-60	BALTO., MD.

9a. FACILITY NAME (If not institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATN	9c. COUNTY OF DEATN
4628 Manerdene	Baltimore City	BALTIMORE CITY

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
MARYLAND	BALTIMORE CITY	BALTIMORE	1 [X] YES 2 [ ] NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4628 MANORDENE ROAD	21229	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] YES 2 [X] NO	1 [ ] YES 2 [X] NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 5 +)	PORTER	

17. FATHER'S NAME (First, Middle, Last)	18. MOTNER'S NAME (First, Middle, Maiden Surname)
JAMES PHILLIP MORGAN SR.	THELMA LOU MINOR

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
RENEE MORGAN	4628 MANORDENE ROAD (21229)

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)	MOUNT ZION CEMETERY	BALTIMORE, MARYLAND

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶ Lynette K. Jones	BROWN-THOMPSON F.H. P.O. BOX 4433(21223)

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Drug Intoxication	
	DUE TO (OR AS A CONSEQUENCE OF): BRONCHOPNEUMONIA	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

CHRONIC ALCOHOL, COCAINE AND HERION ABUSE

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 [X] YES 2 [ ] NO	[X] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATN (Check only one)	
1 [X] YES 2 [ ] NO	HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [X] Residence 6 [ ] Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined.	3-30-89	M	1 [ ] YES 2 [X] NO	unknown

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
home	4628 Manordene

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [X] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
James Kaplan	OCME	▶ 3-31-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
James Kaplan,M.D.	111 Penn Street,Baltimore,MD 21201 vc

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
APR 4 1989	Gina Davidson-Randall

DNMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37837

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within ___ hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, ___ should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): ~~BABY BOY~~ ~~HARRISON~~: KEVIN WARDELL DASHIELLS, JR.

2. DATE OF DEATH — MONTH: 5 DAY: 4 YEAR: 89

3. TIME OF DEATH: 2:10 P.M

4. SOCIAL SECURITY NUMBER:

5. SEX: 1 ☒ M 2 ☐ F

6. AGE (In yrs. last birthday) YRS.: — IF UNDER 1 YEAR: MONTHS: — DAYS: — IF UNDER 24 HRS.: HOURS: 11 MIN.: 37

7. DATE OF BIRTH (Month, Day, Year): 5/4/89

8. BIRTHPLACE (State or Foreign Country): MD.

9a. FACILITY NAME (If not institution, give street and number): MERCY MEDICAL CENTER

9b. CITY, TOWN OR LOCATION OF DEATH: BALTIMORE

9c. COUNTY OF DEATH: —

RESIDENCE OF DECEDENT

10a. STATE: MD

10b. COUNTY: —

10c. CITY, TOWN OR LOCATION: BALTIMORE

10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO

10e. STREET AND NUMBER: 2016 N PULASKI ST

10f. ZIP CODE: 21217

10g. CITIZEN OF WHAT COUNTRY?: USA

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced

12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES

13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:

14. RACE — American Indian, Black, White, etc. Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)
Elementary/Secondary (0-12): —
College (1-4 or 5 +): —

16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): INFANT

16b. KIND OF BUSINESS/INDUSTRY:

17. FATHER'S NAME (First, Middle, Last): KEVIN WARDELL DASHIELLS

18. MOTHER'S NAME (First, Middle, Maiden Surname): LYNDRIA ANTENETTE

19a. INFORMANT'S NAME (Type/Print): R. GUTBERLET

19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2016 N PULASKI ST, BALTO, MD

20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 6 ☐ Other (Specify)

20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place):

20c. LOCATION — City or Town, State:

21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ MARSH FUNERAL HOME

22. NAME AND ADDRESS OF FACILITY:

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	PULMONARY INTERSTITIAL EMPHYSEMA	LIFE
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	HYALINE MEMBRANE DISEASE	LIFE
DUE TO (OR AS A CONSEQUENCE OF):		
c.	PREMATURITY	LIFE
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.:

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO

26. PLACE OF DEATH (Check only one)
HOSPITAL: 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA
OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH: 1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 ☐ Pending Investigation 6 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year):

28b. TIME OF INJURY M:

28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO

28d. DESCRIBE HOW INJURY OCCURED:

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify):

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State):

29a. CERTIFIER (Check only one)
1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(a) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(a) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Ronald J. Gutberlet, M.D.

29c. LICENSE NUMBER: D03588

29d. DATE SIGNED (Month, Day, Year) ▶ 3/28/90

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): RONALD L. GUTBERLET, MD. — MERCY MEDICAL CENTER

31. DATE FILED (Month, Day, Year): JUN 3 - 91

32. REGISTRAR'S SIGNATURE: Linda Davidson-Rendall

DHMH-16 Rev 1/89

#1 & 17 per B.C. 8/7/91 kam

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37838

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Joy Marie .. Moore
2. DATE OF DEATH: MONTH 11 DAY 27 YEAR 89
3. TIME OF DEATH: 7 20 P.M.
4. SOCIAL SECURITY NUMBER: N/A
5. SEX: 1 [X] M 2 [ ] F
6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. 15 Sec
7. DATE OF BIRTH (Month, Day, Year): 11-27-89
8. BIRTHPLACE (State or Foreign Country): MD
9a. FACILITY NAME (If not institution, give street and number): Saint Joseph Hospital
9b. CITY, TOWN OR LOCATION OF DEATH: TOWSON
9c. COUNTY OF DEATH: BALTIMORE

RESIDENCE OF DECEDENT

10a. STATE: MD
10b. COUNTY: BALTIMORE
10c. CITY, TOWN OR LOCATION: TOWSON
10d. INSIDE CITY LIMITS? 1 [ ] YES 2 [X] NO
10e. STREET AND NUMBER:
10f. ZIP CODE:
10g. CITIZEN OF WHAT COUNTRY?
11. MARITAL STATUS: 1 [X] Never Married 2 [ ] Married 3 [ ] Widowed 4 [ ] Divorced
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [X] NO — IF YES, GIVE WAR OR DATES
13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES 2 [X] NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) — College (1-4 or 5+)
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)
16b. KIND OF BUSINESS/INDUSTRY
17. FATHER'S NAME (First, Middle, Last): Warren Nelson Moore
16. MOTHER'S NAME (First, Middle, Maiden Surname): Geraldine McFadden
19a. INFORMANT'S NAME (Type/Print)
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
20a. METHOD OF DISPOSITION: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): ST. Joseph Hosp.
20c. LOCATION — City or Town, State: TOWSON Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE
22. NAME AND ADDRESS OF FACILITY: 7620 York Rd ST. Joseph Hospital, TOWSON, Md

7/120

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Prematurity
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. DUE TO (OR AS A CONSEQUENCE OF):
c. DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 [X] YES 2 [ ] NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [X] YES 2 [ ] NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [X] NO
26. PLACE OF DEATH (Check only one) — HOSPITAL: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA — OTHER: 4 [ ] Nursing Home 5 [ ] Residence 8 [ ] Other (Specify)
27. MANNER OF DEATH: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined
28a. DATE OF INJURY (Month, Day, Year)
28b. TIME OF INJURY M
28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO
28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 [X] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.
29b. SIGNATURE AND TITLE OF CERTIFIER: William F. DeVoe, MD
29c. LICENSE NUMBER: DO 1927
29d. DATE SIGNED (Month, Day, Year): ▶ 2/8/90
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): William F. DeVoe, MD
31. DATE FILED (Month, Day, Year): AUG 01 1991
32. REGISTRAR'S SIGNATURE

DHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37839

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): DORIS J. SHIELDS		2. DATE OF DEATH: MONTH 2 DAY 27 YEAR 89	3. TIME OF DEATH: 11:15 AM
4. SOCIAL SECURITY NUMBER: 367-94-4370	5. SEX: 1 ☐ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS DAYS — IF UNDER 24 HRS.: HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) / 8. BIRTHPLACE (State or Foreign Country): Md.
9a. FACILITY NAME (If not institution, give street and number): Dorchester General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH: Cambridge	9c. COUNTY OF DEATH: Dorchester

RESIDENCE OF DECEDENT

10a. STATE: Md.	10b. COUNTY: Dorchester	10c. CITY, TOWN OR LOCATION: Cambridge	10d. INSIDE CITY LIMITS? 1 ☑ YES 2 ☐ NO
10e. STREET AND NUMBER: 701 Race ST. Cambridge Md.	10f. ZIP CODE: 21613		10g. CITIZEN OF WHAT COUNTRY?: U.S.A.
11. MARITAL STATUS: 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☑ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☑ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) — Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Yackawac	18. MOTHER'S NAME (First, Middle, Maiden Surname): Dorothy Robbins		
19a. INFORMANT'S NAME (Type/Print): James Shields	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 412 Elizabeth ST. Salisbury Md.		
20a. METHOD OF DISPOSITION: 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): Bethel Ceme — DATE	20c. LOCATION — City or Town, State: Cambridge, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Janella C. Hu	22. NAME AND ADDRESS OF FACILITY: 510 Washington ST. Camb. Md.		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Fatty Liver	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	c.	
	DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.: Obesity, Pseudotumor cerebrum (history), Hypertension (history)

24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO

24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☒ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☒ YES 2 ☐ NO

26. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☒ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

27. MANNER OF DEATH: ☒ 1 Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 8 ☐ Could not be determined

28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
	M	1 ☐ YES 2 ☐ NO	

28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)

28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☒ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
Mario F. Golle, Jr. M.D.	OCME	▶ Re-issued 12-27-91

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Mario F. Golle, Jr., M.D., Assistant 111 Penn Street, Baltimore, MD 21201

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
DEC 27 1991	Julia Davidson-Randall

DHMH-18 Rev 1/89

89-37840

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Baby Girl Kanu			2. DATE OF DEATH (Month, Day, Year): 11 - 13 - 89	3. TIME OF DEATH: 1:15 a M
4. SOCIAL SECURITY NUMBER	5. SEX: 1 ☐ M 2 ☒ F	5. AGE (In yrs. last birthday): YRS.	IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 1 / MIN. 45	7. DATE OF BIRTH (Month, Day, Year): 11 - 12 - 89	8. BIRTHPLACE (State or Foreign Country): Maryland
9a. FACILITY NAME (If not institution, give street and number): Prince George's Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH: Cheverly	9c. COUNTY OF DEATH: Prince George's

RESIDENCE OF DECEDENT

10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION	10d. INSIDE CITY LIMITS?
Maryland	Prince George's	Riverdale	1 ☐ YES 2 ☐ NO

10e. STREET AND NUMBER	10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
6914 Furman Parkway	20737	USA

11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. RACE — American Indian, Black, White, etc.
1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ YES 2 ☐ NO IF YES, GIVE WAR OR DATES	1 ☐ YES 2 ☐ NO Specify:	Specify: BLACK

15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)	College (1-4 or 8+)		

17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)
	Amie Kanu

19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)
AMIE KANU	6914 FURMAN PARKWAY RIVERDALE, Md 20737

20a. METHOD OF DISPOSITION	20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)	20c. LOCATION — City or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify): Hospital		

21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY
▶	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) →
a. Cardio Respiratory Arrest
DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST
b. Severe Prematurity
DUE TO (OR AS A CONSEQUENCE OF):
c.
DUE TO (OR AS A CONSEQUENCE OF):
d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
1 ☐ YES 2 ☒ NO	1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)	
1 ☐ YES 2 ☐ NO	HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA	OTHER: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify)

27. MANNER OF DEATH	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED
1 ☒ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending investigation 6 ☐ Could not be determined		M	1 ☐ YES 2 ☐ NO	
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
M.D.	D 36014	▶ 11-13-89

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)
STEPHEN KEITH M.D. PRINCE GEORGE'S MEDICAL CTR. CHEVERLY, MD

31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE
NOV 08 '90	Linda Davidson-Randall

DHMH-18 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37841

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within [illegible] hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): JUNIOR LEE			2. DATE OF DEATH (Month, Day, Year): 12 04 89	3. TIME OF DEATH: 0652 A M
4. SOCIAL SECURITY NUMBER: 900-19-6452	5. SEX: 1 ☒ M 2 ☐ F	6. AGE (In yrs. last birthday): YRS. — IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS 2 / MIN. 53	7. DATE OF BIRTH (Month, Day, Year): 12-4-89	8. BIRTHPLACE (State or Foreign Country): MD.
8a. FACILITY NAME (If not institution, give street and number): PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH: SALISBURY, MARYLAND		9c. COUNTY OF DEATH: WICOMICO

RESIDENCE OF DECEDENT

10a. STATE: MD	10b. COUNTY: SOMERSET	10c. CITY, TOWN OR LOCATION: PRINCESS ANNE 21853	10d. INSIDE CITY LIMITS? 1 ☒ YES 2 ☐ NO
10e. STREET AND NUMBER: RT 3 BOX 374		10f. ZIP CODE: 21853	10g. CITIZEN OF WHAT COUNTRY?: US

11. MARITAL STATUS: 1 ☒ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☒ NO — IF YES, GIVE WAR OR DATES	13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): NA; College (1-4 or 6+): NA	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): NA	16b. KIND OF BUSINESS/INDUSTRY: NA	
17. FATHER'S NAME (First, Middle, Last): STEVEN ALLEN LEE		18. MOTHER'S NAME (First, Middle, Maiden Surname): BRENDA ROSE MEYER	
19a. INFORMANT'S NAME (Type/Print): BRENDA CHEW		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): Rt. 3 Box 374 Princess Anne MD 21853	
20a. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): PENINSULA GENERAL HOSPITAL	20c. LOCATION — City or Town, State: SALISBURY Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Karen C. Parker (Sexton)		22. NAME AND ADDRESS OF FACILITY: Peninsula General Hospital Medical Ctr. 100 E. CARROLL ST. SALISBURY, Md. 21801	

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a.	CARDIAC ARREST	
DUE TO (OR AS A CONSEQUENCE OF):		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST — b.	IMMATURE LABOR AND DELIVERY	
DUE TO (OR AS A CONSEQUENCE OF):		
c.	INCOMPETANT CERVIX.	
DUE TO (OR AS A CONSEQUENCE OF):		
d.		

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. WAS AN AUTOPSY PERFORMED? 1 ☐ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)		
27. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
	28d. DESCRIBE HOW INJURY OCCURED		
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Kevin Kearney M.D.	29c. LICENSE NUMBER: D17029	29d. DATE SIGNED (Month, Day, Year): ▶ 12/14/89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): KEVIN C. KEARNEY M.D. 560 RIVERSIDE D. SALISBURY, MD. 21801		
31. DATE FILED (Month, Day, Year): MAR 25 '92	32. REGISTRAR'S SIGNATURE: Julia Davidson-Pinkett	

OHMH-16 Rev 1/89

1 - FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37842

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Christopher Micheal Jones			2. DATE OF DEATH (Month, Day, Year): 07 04 1989	3. TIME OF DEATH: 1225 PM
4. SOCIAL SECURITY NUMBER	5. SEX: 1 [X] M 2 [ ] F	6. AGE (In yrs. last birthday) YRS. / IF UNDER 1 YEAR: MONTHS / DAYS / IF UNDER 24 HRS.: HOURS 1 / MIN. 57	7. DATE OF BIRTH (Month, Day, Year): 07.04.1989	8. BIRTHPLACE (State or Foreign Country)
9a. FACILITY NAME (If not institution, give street and number): Montgomery General Hospital	9b. CITY, TOWN OR LOCATION OF DEATH: Olney		9c. COUNTY OF DEATH: Montgomery	

RESIDENCE OF DECEDENT

10a. STATE: Maryland	10b. COUNTY: Montgomery	10c. CITY, TOWN OR LOCATION: Silver Spring	10d. INSIDE CITY LIMITS? [X] YES 2 [ ] NO
10e. STREET AND NUMBER: 14130 Grand Pre Road, #31		10f. ZIP CODE: 20906	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: Infant (1 Never Married 2 Married 3 Widowed 4 Divorced)	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 [ ] YES 2 [ ] NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] YES [X] NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: Black

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12) / College (1-4 or 5+)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): none	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): Donald Lewis Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname): Sheila Deloris Tingle	
19a. INFORMANT'S NAME (Type/Print): Sheila D. Tingle	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 14130 Grand Pre Road, #31, S.S., 20906		
20a. METHOD OF DISPOSITION: 1 [ ] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 6 [X] Other (Specify) disposal	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place): hospital / DATE	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ N/A	22. NAME AND ADDRESS OF FACILITY		

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEVERE IMMATURITY (NONCURABLE)

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b.

DUE TO (OR AS A CONSEQUENCE OF):

c.

DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? 1 [ ] YES 2 [ ] NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 [ ] YES 2 [ ] NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 [ ] YES 2 [ ] NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA	OTHER: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)	
27. MANNER OF DEATH: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined	28a. DATE OF INJURY (Month, Day, Year) / 28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 [ ] YES 2 [ ] NO	28d. DESCRIBE HOW INJURY OCCURED
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

29a. CERTIFIER (Check only one)
1 [ ] CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 [ ] MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER: Maria del Rosario F. Ames	29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year) ▶ 2/28/92

30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): Maria del Rosario F. Ames

31. DATE FILED (Month, Day, Year): MAY 15 '92	32. REGISTRAR'S SIGNATURE

DNMN-16 Rev 1/89

Orig. lost in DVR 9/17/92 kam FilmG691

3 - OFFICE

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37843

1. DECEDENT'S NAME (First, Middle, Last): Robert I. Shouman				2. DATE OF DEATH (Month, Day, Year): 9-4-89		3. TIME OF DEATH: 10:30PM M	
4. SOCIAL SECURITY NUMBER: 212-08-0227 / 212-08-0277	5. SEX: 1 X M 2 ☐ F	6. AGE (In yrs. last birthday): 18 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	7. DATE OF BIRTH (Month, Day, Year): 09 06 39	8. BIRTHPLACE (State or Foreign Country): MARYLAND	
9a. FACILITY NAME (If not institution, give street and number): I-83 & Northern Parkway			9b. CITY, TOWN OR LOCATION OF DEATH: Baltimore City		9c. COUNTY OF DEATH		

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RESIDENCE OF DECEDENT

10a. STATE: MARYLAND	10b. COUNTY	10c. CITY, TOWN OR LOCATION: BALTIMORE	10d. INSIDE CITY LIMITS? 1 X YES 2 ☐ NO
10e. STREET AND NUMBER: 3626 ELM AVENUE 1306		10f. ZIP CODE: 21211	10g. CITIZEN OF WHAT COUNTRY? USA

11. MARITAL STATUS: 1 X Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 X NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 X NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: WHITE

15. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 10TH / College (1-4 or 5+):	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.): Never Worked	16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last): HARRY H, SHOUMAN, SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname): MARY BRADFORD	
19a. INFORMANT'S NAME (Type/Print): MARY BRADFORD SHOUMAN		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 5200 CLIFTON AVENUE, BALTIMORE, MARYLAND 21207	
20a. METHOD OF DISPOSITION: 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): DULANEY VALLEY MEMORIAL GARDENS	20c. LOCATION — City or Town, State: TOWSON, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ A Alan Seitz, Jr.		22. NAME AND ADDRESS OF FACILITY: A. ALAN SEITZ, JR. FUNERAL HOME 3615-19 CHESTNUT AVE., BALTO., MD. 21211	

23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

		Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Cranio-cerebral injuries	
	DUE TO (OR AS A CONSEQUENCE OF):	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF):	
	c. DUE TO (OR AS A CONSEQUENCE OF):	
	d.	

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PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

	24a. WAS AN AUTOPSY PERFORMED? X YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? X YES 2 ☐ NO

25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 ☐ NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) Scene			
27. MANNER OF DEATH: 1 ☐ Natural X Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined	28a. DATE OF INJURY (Month, Day, Year): 9-4-89	28b. TIME OF INJURY: 10:00PM	28c. INJURY AT WORK? 1 ☐ YES X NO	28d. DESCRIBE HOW INJURY OCCURRED: autos Driver in auto/auto collision
	28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify): Road			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State): I-83 & Northern Pkwy., Baltimore City, Maryland

29a. CERTIFIER (Check only one)
1 ☐ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occured at the time, date and place, and due to the cause(s) and manner as stated.

29b. SIGNATURE AND TITLE OF CERTIFIER	29c. LICENSE NUMBER: OCME	29d. DATE SIGNED (Month, Day, Year): ▶ 9-5-89
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print): James Kaplan, M.D. 111 Penn Street, Baltimore, Maryland 21201 VC		
31. DATE FILED (Month, Day, Year): SEP 7	32. REGISTRAR'S SIGNATURE	

DHMH-10 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

1 - FOR STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37844

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST: VIRGINIA T. WILLSON

2a. DATE OF DEATH MONTH DAY YEAR: February 9, 1989

2b. HOUR: 4:20 P M

3. SEX: Female

4. RACE: White

5. DATE OF BIRTH MONTH DAY YEAR: March 25, 1905

6. AGE (IN YEARS LAST BIRTHDAY): 83 Yrs

IF UNDER 1 YEAR MONTHS DAYS: IF UNDER 72 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): Maryland

7b. CITIZEN OF WHAT COUNTRY?: USA

8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

9. BALTIMORE CITY OR COUNTY OF DEATH: Kent MD.

10. CITY OR TOWN OF DEATH: Rock Hall

11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): At Home

12a. USUAL OCCUPATION (TYPE OF WORK DONE MOST OF WORKING LIFE): School Teacher

12b. KIND OF BUSINESS OR INDUSTRY: Public Schools

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE: Maryland

13b. COUNTY: Kent

13c. CITY OR TOWN: Rock Hall

13d. INSIDE CITY LIMITS? YES [ ] NO [X]

13e. STREET ADDRESS / ZIP CODE: Skinner's Neck 21661

14. FATHER'S NAME FIRST MIDDLE LAST: Harry A. Thompson

15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST: Addie L. Parsons

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN): no

(IF YES, GIVE WAR OR DATES)

16b. SOCIAL SECURITY NO.: 149 24 6426

17. INFORMANT: Wm. Francis Willson

ADDRESS: Skinner's Neck Rock Hall, Md. 21661

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE 1a) CARDIO PULMONARY ARREST

Conditions, if any, which gave rise to immediate cause 1a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF 1b) TOXIC FAILURE

DUE TO, OR AS A CONSEQUENCE OF 1c) EXISTING CANCER

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY? YES [ ] NO [ ]

20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES [ ] NO [ ]

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19

21c. HOW INJURY Ooccurred (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]

21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)

21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that I (this hospital) attended the deceased from 12/20/88, 19__, to 2/9/89, 19__, that I (we) last saw the deceased alive on 2/9/89, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John C. Seymour M.D.

DEGREE: ATTENDING PHYSICIAN [X] MEDICAL DIRECTOR [ ] STAFF PHYSICIAN [ ]

22c. DATE SIGNED: Feb. 10, 1989

22d. PHYSICIAN'S NAME (TYPE OR PRINT): JOHN C. SEYMOUR M.D.

22e. ADDRESS: Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SPECIFY): Burial

23b. DATE: 2/12/89

23c. NAME OF CEMETERY OR CREMATORY: Wesley Chapel Cemetery

23d. LOCATION CITY OR TOWN COUNTY STATE: Rock Hall, Md. 21661

24. FUNERAL DIRECTOR (SIGNATURE): J Willis Wells

ADDRESS: J. Willis Wells Chestertown, Md.

25a. DATE REC'D BY REGISTRAR: FEB 10 '89

25b. REGISTRAR'S SIGNATURE: Julia Davidson-Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP 8

DHMH - 16 50M 1/81 (VRA 15, 4)

025218-MAR 1 F89

Info.per B.C. 6/12/90 kam

FOR STATE REGISTRAR FilmG664

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37845

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

1. DECEASED NAME (TYPE OR PRINT) First: Baby Boy ~~Shepperson~~	Middle:	Last: Sheppardson	2a. DATE OF DEATH Month: 2 Day: 21 Year: 89	2b. HOUR 5 30 P.M.	
3. SEX: Male	4. RACE: Black	5. DATE OF BIRTH Month: Feb. Day: 21 Year: 1989	6. AGE (IN YEARS LAST BIRTHDAY) YRS. Infant	IF UNDER 1 YEAR Months: Days:	IF UNDER 24 HRS. Hours: 7 Min: 15
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. BALTIMORE CITY OR COUNTY OF DEATH: Baltimore City MD.		
10. CITY OR TOWN OF DEATH: Balt.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS): Mercy	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		

USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS
Maryland	----	Baltimore	YES ☒ NO ☐	617 Gutman Avenue, 21218

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
~~Norman~~	~~Dean~~	~~Scott~~	MARGUERITE	Sheppardson	~~Young~~

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	(IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
NO				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity

DUE TO, OR AS A CONSEQUENCE OF (b): Preterm Labor

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. P.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET / CITY OR TOWN / COUNTY / STATE	

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Peter C Manuelos	ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐	2/21/89

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN / COUNTY / STATE
Removal	3-2-89		

24. FUNERAL DIRECTOR NAME	ADDRESS	25a. DATE REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
State Anatomy Board	Balto., Md.	MAR 0 9 1989	Gisha Davidson-Kendall

BP_____

DHMH - 1650M 1/81 (VRA 15, 4)

FOR STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 89-37846

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEDENT'S NAME (First, Middle, Last): Florence K. Schwartz
2. DATE OF DEATH (Month, Day, Year): September 1, 1989
3. TIME OF DEATH: 1:55 P. M.
4. SOCIAL SECURITY NUMBER: 184-07-5005
5. SEX: 1 ☐ M 2 ☒ F
6. AGE (In yrs. last birthday): 78 YRS
7. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
8. DATE OF BIRTH (Month, Day, Year): Nov. 19, 1910
9. BIRTHPLACE (State or Foreign Country): Pennsylvania
10. RESIDENCE (If not institution, give street and number): Fernwood House
11. CITY, TOWN OR LOCATION OF DEATH: Bethesda
12. COUNTY OF DEATH: Montgomery
13A. STATE: Maryland
13B. COUNTY: Montgomery
13C. CITY, TOWN OR LOCATION: Chevy Chase
13D. INSIDE CITY LIMITS? XXX 1 ☐ YES 2 ☐ NO
14A. STREET AND NUMBER: 4701 Willard Avenue
14B. ZIP CODE: 20815
14C. CITIZEN OF WHAT COUNTRY: U. S. A.
15. MARITAL STATUS: 1 ☐ Never Married 2 ☐ Married 3 ☐ Divorced 4 ☐ Widowed 5 ☐ Unknown
16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☐ YES 2 ☐ NO — IF YES, GIVE WAR OR DATES
17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 XXX NO
18. RACE — American Indian, Black, White, etc. (Specify): White
19. DECEDENT'S EDUCATION (Specify only highest grade completed): Elementary/Secondary (0-12): 12 Years; College (1-4 or 5+):
20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do not use retired): Homemaker
20B. KIND OF BUSINESS/INDUSTRY: Own Home
21. INFORMANT'S NAME (First, Middle, Last): William Slavitt
22. MOTHER'S NAME (First, Middle, Maiden Surname): Minnie Shapiro
23. INFORMANT'S NAME (Specify): Edward S. Schwartz
23B. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code): 1928 Belmont Road, N. W., Washington, D. C.
24. METHOD OF DISPOSITION: 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)
25A. PLACE OF DISPOSITION (Name of cemetery, crematory or other place): King David Memorial Garden
25B. LOCATION — City or Town, State: Falls Church, Virginia
26. SIGNATURE OF FUNERAL SERVICE LICENSEE: ▶ Donald M. Stein
26B. NAME AND ADDRESS OF FACILITY: DONALD M. STEIN HEB. MEM. FUNERAL HOME 232 CARROLL ST., N.W., WASHINGTON, D. C.

27. PART I. Enter the chronological sequence of events which caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC COLON CANCER — Approximate Interval Between Onset and Death: 1 MONTH

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST

b. DUE TO (OR AS A CONSEQUENCE OF):

c. DUE TO (OR AS A CONSEQUENCE OF):

d.

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28A. WAS AN AUTOPSY PERFORMED? 1 ☐ YES XXX NO

28B. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO

29. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☐ NO

30. PLACE OF DEATH (Check only one): HOSPITAL: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA — OTHER: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

31. MANNER OF DEATH: 1 ☐ Natural 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 5 ☐ Pending Investigation 6 ☐ Could not be determined

32A. DATE OF INJURY (Month, Day, Year)
32B. TIME OF INJURY
32C. INJURY AT WORK? 1 ☐ YES 2 ☐ NO
32D. DESCRIBE HOW INJURY OCCURRED
32E. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
32F. LOCATION (Street and Number or Rural Route Number, City or Town, State)

33. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ☐ MEDICAL EXAMINER: On the basis of examination, and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SIGNATURE AND TITLE OF CERTIFIER: Jon M. Wiseman
33B. LICENSE NUMBER: 12590 DC
33C. DATE SIGNED (Month, Day, Year): ▶ 18 Sept 89

34. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type or Print): Jon M. Wiseman, M. D. 5410 Connecticut Avenue, N.W., Washington, D. C. 20015

35. DATE FILED (Month, Day, Year): SEP 7 1989
36. REGISTRAR'S SIGNATURE:

D-MH-18 Rev 1/88

Missing in Index
See for
No Record in Index

03 02 96 12:48PM

Theresa
554-2107
ER
Death

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 89 37847

Certificate of Death

Reg. No.

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)	2. Date of Death Month / Day / Year	3. Time of Death
George Pollock	03 / 01 / 89	11:50 pm

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
St Agnes Hospital	Baltimore	N/A

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
083-36-5656	1☒ M 2☐ F	89 Yrs.			June 5, 1899	Maryland

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
Maryland	Baltimore	Randallstown	1☐ Yes 2☒ No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
27 Sheraton Road	21133	U.S.A.

11. Marital Status	12. Was Decedent Evar in U.S. Armed Forcas?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Maxican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1☐ Never Married 2☒ Married 3☐ Widowed 4☐ Divorced	1☒ Yes 2☐ No If Yas, Give Year or Dates WWI WWII /Korea	1☐ Yes 2☒ No Specify:	Specify: White

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
12	4 Years	Development Officer	U.S. Government

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maidan Surnema)
George F. Pollock	Cora L. Williams

19a. Informant's Name/Ralationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Mrs. Dorothy Pollock	27 Sheraton Road Randallstown, MD 21133

20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, cremetory or other piece)	Date	20c. Location - City or Town, State
1☒ Burial 2☐ Cremation 3☐ Removal from State 4☐ Donation 5☐ Other (Specify)	Monocacy Cemetery	3/4/89	Beallsville,Maryland

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Stephen M Jenkins	Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or raspiretory errest, shock, or haart failura. List only ona cause on aach line.

Approximate Interval Between Onsat and Death

Immediate Cause (Final disease or condition resulting in death)
a. Sepsis

Dua to (or as a consequanca of):

Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or injury thaf Initiated events resulting in death) Last
b.

Due to (or as a consequenca of):
c.

Dua to (or as a consequanca of):
d.

Part II. **Other significant conditions** contributing to death but not rasulting in the underlying cause given in Part I.

New onset diabetes mellitus

Dehydration

23b. Did tobacco use contribute to the ceuse of death? 1☐ Yes 2☑ No 3☐ Probably 4☐ Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1☐ Yes 2☑ No	1☐ Yes 2☐ No

25. Was case referrad to medical examiner? 1☐ Yes 2☑ No

26. Place of Death (Check only one)
Hospital: 1☑ Inpatient 2☐ ER/Outpatient 3☐ DOA
Other: 4☐ Nursing Home 5☐ Rasidance 6☐ Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred
1☑ Natural 2☐ Accident 3☐ Suicide 4☐ Homicide 5☐ Panding investigation 6☐ Could not ba determined		M	1☐ Yas 2☐ No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)
1☑ **Certifying Phyaician**: To tha best of my knowledga, daath occurred at tha tima, data and placa, and due to the cause(s) and mannar as stated.
2☐ **Medical Examiner**: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha tima, data and placa, and dua to the causa(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Data signad (Month, Day, Year)
▶ M S Ochaney MD	D - 40521	July 9, 1998

30. Name and address of parson who complatad causa of death (Item 23a) (Typa, Print)
M.S. Ochaney, M.D. 900 Caton Avenue Baltmore, MD 21229

State Registrar

31. Data filed (Month, Day, Year)	32. Registrar's Signature
JUL 13 1998	Julia Davidson-Randall

DHMH 16 Rev 6/95

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

NAME

There is no indication that the orginial death certificate was filed with DVR
new certificate generated by hospital & Funeral Home 7/9/98 & filed 7/13/98
reb/gs

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 89-37848

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Ronald Michael Plichta
2. Date of Death: Month May Day 4 Year 1989
3. Time of Death: 6:39Pm.
4a. Facility Name (If not institution, give street and number): Franklin Square Hospital
4b. City, Town, or Location of Death: Baltimore
4c. County of Death: Baltimore

Funeral Director

5. Social Security Number: 220-36-3637
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 50 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 7/16/38
9. Birthplace (State or Foreign Country): Baltimore, MD.

Usual Residence of Decedent

10a. State: Maryland
10b. County: Harford
10c. City, Town or Location: Forest Hill
10d. Inside City Limits: 1 [ ] Yes 2 [X] No
10e. Street and Number: 825 Blake Drive
10f. Zip Code: 21050
10g. Citizen of What Country?: U.S.A.

11. Marital Status: 1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:
13. Wes Decedent of Hispanic Origin? (Specify Yes or No- It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Bleck, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 4 yrs
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Computer Programmer
16b. Kind of Business/Industry: State Of Maryland
17. Father's Name (First, Middle, Last): Leo Plichta
18. Mother's Name (First, Middle, Maiden Surname): Ann Palmisano
19a. Informant's Name/Relationship (Type, Print): Bonnie J. Plichta
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 825 Blake Drive Forest Hill, MD. 21050
20a. Method of Disposition: 1 [X] Burial 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Place of Disposition (Name of cemetery, crematory or other place): Moreland Memorial Park
Date: 5/8/1989
20c. Location - City or Town, State: Baltimore, Maryland
21. Signature of Funeral Service Licensee: Kathleen Murphy Per DVR
22. Name and Address of Facility: John C. Miller, Inc. 6415 Belair Rd. Baltimore, Md. 21206

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death

Immediate Cause (Finel diseasa or condition resulting in death): a. ACUTE MYOCARDIAL INFARCTION — sudden

Due to (or as a consequence of):

b. ASCVD — 2yrs

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [ ] Unknown

24a. Was en autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings availiable prior to completion of cause of death? 1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer? 1 [X] Yes 2 [ ] No

26. Place of Death (Check only one): Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [X] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Manner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how Injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] **Medical Examiner:** On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: Charles F O'Donnell MD
29c. License number: D-09383
29d. Date signed (Month, Day, Year): May 4, 1989

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): Charles F O'Donnell MD 7501 York Road Towson, Md. 21204

State Registrar

31. Date filed (Month, Day, Year): December 31, 1989
32. Registrar's Signature: Julia Davidson-Randall

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.**

To Be Completed by Funeral Director

Medical Certification: To Be Completed by Physician/Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

* Death certificate was never filed.
could not locate original DC IN DVR
New D.C. generated by Field Rep.
gapedce / G. Sparks 5/16/2000

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

RECREATED

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 89 37849

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Joseph Watson
2. Date of Death: Month MARCH Day 03 Year 1989
3. Time of Death: 11:16AM
4a. Facility Name (If not Institution, give street and number): The Francis Scott Key Medical Center
4b. City, Town, or Location of Death: Baltimore
4c. County of Death:

Funeral Director

5. Social Security Number: 218-28-3074
6. Sex: 1 [X] M 2 [ ] F
7. Age (In yrs. last birthday): 56 Yrs. If Under 1 Year: Months / Days. If Under 24 Hrs.: Hours / Min.
8. Date of Birth (Month, Day, Year): 3/26/1932
9. Birthplace (State or Foreign Country): MD

To Be Completed by Funeral Director

Usual Residence of Decedent

10a. State: MD
10b. County:
10c. City, Town or Location: Baltimore
10d. Inside City Limits: 1 [X] Yes 2 [ ] No
10e. Street and Number: 4312 East lombard Street
10f. Zip Code: 21224
10g. Citizen of What Country?: USA

11. Marital Status: 1 [ ] Never Married 2 [ ] Married 3 [ ] Widowed 4 [X] Divorced
12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Yeer or Detes:
13. Was Decedent of Hispanic Origin? (Spacify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:
14. Race - American Indian, Black, White, etc. Specify: White
15. Decedent's Education (Specify only highest grade completed): Elementary/Secondary (0-12): ; College (1-4or 5+): 2+
16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Iron Worker
16b. Kind of Business/Industry: Local #16
17. Father's Name (First, Middle, Last): Joseph E. Watson
18. Mother's Name (First, Middle, Maiden Surname): Edith P. Pishalski
19a. Informant's Name/Relationship (Type, Print): Ralph Watson- Brother
19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code): 3418 Gough St., Baltimore, MD 21224
20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)
20b. Piece of Disposition (Name of cemetery, crematory or other place): Security Process, Inc.
Date: 3/4/1989
20c. Location - City or Town, Stete: Baltimore, MD
21. Signature of Funeral Service Licensee: Joseph N. Zannino
22. Name and Address of Facility: Joseph N. Zannino, Jr. Funeral Home, 263 South Conkling Street, Baltimore, MD 21224

Physician /Medical Examiner

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): a. SEPSIS
Due to (or as a consequence of):
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last:
b. CIRRHOSIS OF LIVER
Due to (or as a consequence of):
c.
Due to (or as a consequence of):
d.

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.: Alcoholic Hepatitis, Gastrointestinal Bleeding

23b. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [ ] No 3 [ ] Probably 4 [X] Unknown

24a. Was an autopsy performed? 1 [ ] Yes 2 [X] No

24b. Were autopsy findings available prior to completion of cause of death? 1 [ ] Yes 2 [X] No

25. Was case referred to medical examiner? 1 [ ] Yes 2 [X] No

26. Place of Death (Check only one): Hospital: 1 [X] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residence 6 [ ] Other (Specify)

27. Menner of Death: 1 [X] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Dete of Injury (Month, Day Year)
28b. Time of Injury M
28c. Injury at Work? 1 [ ] Yes 2 [ ] No
28d. Describe how injury occurred
28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one): 1 [X] **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [ ] **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier:
29c. License number: D26233
29d. Date signed (Month, Day, Year): SEPTEMBER 19, 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANCIS KUHARIDA MD 4940 EASTERN AVENUE BALTIMORE, MARYLAND 21224

State Registrar

31. Date filed (Month, Day, Year): SEP 21 2000
32. Registrar's Signature: Geneva G Sparks

DHMH 16 Rev 6/95

ORIGINAL

Baltimore, Maryland 21215-0020

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. **Important:** If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

1- For State Registrar Amend Item#9,20a-c perDVRG796 6/18/01 EW

Certificate of Death

Reg. No. 89-37850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
Eugene	McFadden	October 31, 1989	10:36A M

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Sinai Hospital	Baltimore	

Funeral Director

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24 Hrs.: Hours / Min.	8. Date of Birth (Month, Day, Year)	9. Birthplace (State or Foreign Country)
578-16-5671	1 XM 2 F	75 Yrs.			March 1, 1914	~~USA~~ SC

Usual Residence of Decedent

10a. State	10b. County	10c. City, Town or Location	10d. Inside City Limits
MD		Baltimore	1 X Yes 2 No

10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
5304 Nelson Avenue		USA

11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
1 X Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates: Unknown	1 X Yes 2 No Specify:	Specify: Black

15. Decedent's Education (Specify only highest grade completed)		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)	18b. Kind of Business/Industry
Elementary/Secondary (0-12)	College (1-4or 5+)		
Unknown		Unknown	Unknown

17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surname)
William McFadden	Addie Wilson

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
Patient's chart	Sinai Hospital Baltimore, MD

20a. Method of Disposition ~~Unknown~~	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or Town, State
1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	Western Star	11/04 /1989	Balto.,Md

21. Signature of Funeral Service Licensee	22. Name and Address of Facility
▶ Willie Parson	Carolina Funeral Service

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

a. Cardiopulmonary arrest

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Metastatic cancer

Due to (or as a consequence of):

c.

Due to (or as a consequence of):

d.

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Date of delivery Month Day Year
1 Yes 2 No 9 Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown	

Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 X Unknown

24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
1 Yes 2 X No	1 Yes 2 No

25. Was case referred to medical examiner?	28. Place of Death (Check only one)	
1 X Yes 2 No (2001)	Hospital: 1 XInpatient 2 ER/Outpatient 3 DOA	Other: 4 Nursing Home 5 Residence 8 Other (Specify)

27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury occurred
1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending investigation 6 Could not be determined			1 Yes 2 No	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 1 **Certifying Physician**: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X **Medical Examiner**: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
▶	OCME	Lost certificate/ re-issued June 8, 2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David R. Fowler, M.D. Acting Chief Medical Examiner, 111 PennSt, Balto.,MD 2120

State Registrar

31. Date filed (Month, Day, Year)	32. Registrar's Signature
JUN 18 2001	▶ Jenna D Sparks

DHMH 17 Rev 1/2001

ORIGINAL

Medical Certification; To Be Completed by Physician/Medical Examiner

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

CPM
90-0261-510
EDWARD McBRIDE
2

RECREATED This document may be a duplicate, Recreated from the Medical Examiners Records.5/17/02dhb

Please T... P... B... T... A... C...

Amend Items 3,11,28a,1... ME,G807,05/17/0... For State Registrar

ATTN: REFERENCE SERVICES
THIS IS A RE-CREATED CERTIFICATE TO BE PLACED IN THE LAST 1989 DEATH BOOK.
THANK YOU
EARL WATSON
VITAL RECORDS
PLEASE CALL WHEN RECEIVED
(410) 764-3089

Physician /Medical Examiner

1. Decedent's Name *(First, Middle, La...*: Edward
4a. Facility Name *(If not institution, gi...*: 2511 Madison Ave
...e of Death: ...7 a M

Funeral Director

5. Social Security Number: 096-32-2590
6. ...
...te or Foreign: ...is
Usual Residence of Decedent
10a. State: MD
10b. County:
...e City Limits: Yes 2 No
10e. Street and Number: 2034 Madison Ave
11. Marital Status: 1 Never Married 2 Married 3 Widowed 4 Divorced
...n.
15. Decedent's E... *(Specify only highest gr... completed)*
Elementary/Secondary (0-12):
College (1-4or 5+): 4 yrs
(Give kind of work done during most of working life. DO NOT use retired): Salesman
Computers
17. Father's Name *(First, Middle, Last)*: Eddie McBride
18. Mother's Name *(First, Middle, Maiden Surname)*: Marie Langston
19a. Informent's Name/Relationship *(Type, Print)*: Margaret E. McBride
19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*: 2034 Madison Avenue, Balto, MD 21217
20a. Method of Disposition: 1 Buriet 2 X Cremation 3 Removal from State 4 Donation 5 Other *(Specify)*
20b. Place of Disposition *(Name of cemetery, crematory or other place)*: Metro Crematory, Inc.
Date:
20c. Location - City or Town, Stete: Baltimore, MD
21. Signature of Funeral Service Licensee: George E. MacNabb, per DVR
22. Name and Address of Facility: Cremation Society of MD, Baltimore, MD 21228

Physician /Medical Examiner

23e. Pert1. Enter the diseese, or complicetions that ceused the deth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one ceuse on each line.
Approximate Interval Between Onset and Death

Immediete Cause (Finat disease or condition resulting in deth): a. Multiple Stab Wounds

Sequentially list conditions, if any, leeding to immediete cause. Enter Underlying Cause (Diseese or injury thet initieted events resulting in death) Last:
b. Due to (or as a consequence of):
c. Due to (or as a consequence of):
d. Due to (or as a consequence of):

IF FEMALE:
23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown
23c. If yes, outcome of pregnancy: 1 Live birth 2 Fetel deth 3 Ectopic pregnency 4 Pregnent et time of death 5 Other *(specify)* 9 Unknown
23d. Dete of delivery: Month Day Year

Pert II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Pert I.

23e. Did tobecco use contribute to the cause of deeth? 1 Yes 2 X No 3 Probably 4 Unknown

24a. Was an autopsy performed? 1 X Yes 2 No
24b. Were autopsy findings available prior to completion of ceuse ot death? X Yes 2 No

25. Wes case referred to medical examiner? 1 X Yes 2 No
26. Place of Death *(Check only one)*: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA; Other: 4 Nursing Home 5 Residence 6 X Other *(Specify)* SCENE

27. Menner of Death: 1 Natural 2 Accident 3 Suicide 4 X Homicide 5 Pending investigation 6 Could not be determined
28a. Dete of Injury ~~UNK~~ *(Month, Day Year)*: 10/7/89
28b. Time of Injury: UNK M
28c. Injury at Work? 1 Yes 2 X No
28d. Describe how injury occurred: Subject Stabbed
28e. Place of Injury - At home, ferm, street, tactory, office building, etc. *(Specify)*: ~~Apartment building~~ Rear
28t. Location *(Street and Number or Rural Route Number, City or Town, State)*: 2511Madison Avenue Balto.MD

29a. Certifier *(Check only one)*: 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner es steted. 2 X Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and manner stated.
29b. Signature and title of certifier: For David R Fowler MD
29c. License number: OCME
29d. Dete signed *(Month, Day, Year)*: REISSUED MAY 8, 2002
30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK PERETTI, MD 111 Penn Street, Baltimore, Maryland 21201

State Registrar

31. Date filed *(Month, Day, Year)*: FEB 08 '90
32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

Baltimore, Maryland 21215-0036

permi. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-t show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Medical Certification: To Be Completed by Physician/Medical Examiner

CPM
90-0261-510
EDWARD McBRIDE
2

RECREATED This document may be a duplicate, Recreated

Please Type or Print in Black Indelible Ink. Ensure A...

Amend Items 3,11,28a,e per ME,G807,05/17/02dhb

For State Registrar

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 89-37850

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last): Edward McBride

2. Date of Death Month: ~~1~~ OCTOBER Day: ~~17~~ 7 Year: ~~90~~ 1989

3. Time of Death: ~~10:17~~ a M

4a. Facility Name (If not institution, give street and number): 2511 Madison Avenue-rear

4b. City, Town, or Location of Death: Baltimore

4c. County of Death:

Funeral Director

5. Social Security Number: 096-32-2590

6. Sex: 1 [X] M 2 [ ] F

7. Age (In yrs. last birthday): 48 Yrs.

If Under 1 Year: Months / Days

If Under 24 Hrs.: Hours / Min.

8. Date of Birth (Month, Day, Year): April 25,1941

9. Birthplace (State or Foreign Country): Illinois

Usual Residence of Decedent

10a. State: MD

10b. County:

10c. City, Town or Location: Baltimore

10d. Inside City Limits: 1 [ ] Yes 2 [ ] No

10e. Street and Number: 2034 Madison Avenue

10f. Zip Code: 21217

10g. Citizen of What Country? USA

11. Marital Status: 1 [X] ~~Never~~ Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced

12. Was Decedent Ever in U.S. Armed Forces? 1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:

13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 [ ] Yes 2 [X] No Specify:

14. Race - American Indian, Black, White, etc. Specify: Black

15. Decedent's Education (Specify only highest grade completed)

Elementary/Secondary (0-12):

College (1-4or 5+): 4 yrs

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired): Salesman

18b. Kind of Business/Industry: Computers

17. Father's Name (First, Middle, Last): Eddie McBride

18. Mother's Name (First, Middle, Maiden Surname): Marie Langston

19a. Informant's Name/Relationship (Type, Print): Margaret E. McBride

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code): 2034 Madison Avenue, Balto, MD 21217

20a. Method of Disposition: 1 [ ] Burial 2 [X] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place): Metro Crematory, Inc.

Date:

20c. Location - City or Town, State: Baltimore, MD

21. Signature of Funeral Service Licensee: George E. MacNabb, per DVR

22. Name and Address of Facility: Cremation Society of MD, Baltimore, MD 21228

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician /Medical Examiner

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death): Multiple Stab Wounds

a. Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

b. Due to (or as a consequence of):

c. Due to (or as a consequence of):

d.

IF FEMALE:

23b. Was decedent pregnant in the past 12 months? 1 [ ] Yes 2 [ ] No 9 [ ] Unknown

23c. If yes, outcome of pregnancy 1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnant at time of death 5 [ ] Other (specify) 9 [ ] Unknown

23d. Date of delivery Month Day Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 [ ] Yes 2 [X] No 3 [ ] Probably 4 [ ] Unknown

24a. Was an autopsy performed? 1 [X] Yes 2 [ ] No

24b. Were autopsy findings available prior to completion of cause of death? [X] Yes 2 [ ] No

25. Was case referred to medical examiner? 1 [X] Yes 2 [ ] No

28. Place of Death (Check only one)

Hospital: 1 [ ] Inpatient 2 [ ] ER/Outpatient 3 [ ] DOA

Other: 4 [ ] Nursing Home 5 [ ] Residence 8 [X] Other (Specify) SCENE

27. Manner of Death: 1 [ ] Natural 2 [ ] Accident 3 [ ] Suicide 4 [X] Homicide 5 [ ] Pending investigation 6 [ ] Could not be determined

28a. Date of Injury (Month, Day Year) ~~UNK~~ 10/7/89

28b. Time of Injury UNK M

28c. Injury at Work? 1 [ ] Yes 2 [X] No

28d. Describe how injury occurred: Subject Stabbed

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Apartment building ~~Rear~~

28f. Location (Street and Number or Rural Route Number, City or Town, State) 2511Madison Avenue Balto.MD

Medical Certification: To Be Completed by Physician/Medical Examiner

29a. Certifier (Check only one): 1 [ ] Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 [X] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier: For David R Fowler MD

29c. License number: OCME

29d. Date signed (Month, Day, Year) REISSUED MAY 8, 2002

30. Name and address of person who completed cause of death (Item 23a) (Type, Print): FRANK PERETTI, MD 111 Penn Street, Baltimore, Maryland 21201

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

State Registrar

31. Date filed (Month, Day, Year): FEB 08 '90

32. Registrar's Signature

DHMH 17 Rev 1/2001

ORIGINAL

ATTN: REFERENCE
THIS IS A RE-CREATED
CERTIFICATE TO BE PLACED
IN THE LAST 1989 DEATH
BOOK.

THANK YOU
EARL WATSON
VITAL RECORDS

PLEASE CALL WHEN RECEIVED
(410) 764-3089

07-01009
Lester C. Rice, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

1- For State Registrar

Reg. No. 1989-37850

Physician/ Medical Examiner / **Funeral Director**

1. Decedent's Name (First, Middle, Last)	2. Date of Death (Month, Day, Year)	3. Time of Death
Lester C. Rice, Sr.	November 12, 1989	1535 hrs

4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Harford Memorial Hospital	Havre de Grace	Harford

5. Social Security Number	6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year: Months / Days	If Under 24Hrs.: Hours / Min.	8. Date of Birth (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
215-44-1998	1 [X] M 2 [ ] F	44 Yrs.			08/10/1945	MD

Usual Residence of Decedent

10a. Stete	10b. County	10c. City, Town or Locetion	10d. Inside City Limits
PA	Chester	Sharpless Rd., Landingburg PA 19350	1 [ ] Yes 2 [X] No

10e. Street end Number	10f. Zip Code	10g. Citizen of Whet Country?
Box 151 Sharpless Road	19350	USA

11. Meritel Status	12. Wes Decedent Ever In U.S. Armed Forces?	13. Wes Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	14. Rece - American Indien, Bleck, White, etc.
1 [ ] Never Married 2 [X] Married 3 [ ] Widowed 4 [ ] Divorced	1 [ ] Yes 2 [X] No If Yes, Give Year or Dates:	1 [ ] Yes 2 [X] No *specify:*	*Specify:* White

15. Decedent's Educetion (Specify only highest grade completed)		16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
Elementary/Secondary (0-12)	Collage (1-4 or 5+)		
12	0	Carpenter	Industrial

17. Fether's Name (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surneme)
Grover Rice	McFadden

19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural Route Numbar, City or Town, State, Zip Code)
Patricia Marie Rice	Box 151 Sharpless Rd., Landingburg PA 19350

20e. Method of Disposition	20b. Piece of Disposition (Name of cemetery, crematory or other piece)	Date	20c. Location - City or Town, Steta
1 [X] Buriel 2 [ ] Cremation 3 [ ] Removal from State 4 [ ] Donation 5 [ ] Other *Specify:*	Union Hill Cemetery	11/15/89	Kennett Square, PA

21. Signature of Funerel Service Licensee	22. Name end Address of Facility
Robert T. Strawbridge per DVR	Cleveland & Grieco Funeral Home 221-223 Avondale PA 19311

Physician /Medical Examiner / **Medical Certification: To Be Completed by Physician/Medical Examiner**

23a. Part I. Enter the diseese, or complicetions thet caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, shock, or heert failure. List only one cause on each line.	Approximete Intervel Between Onset and Deeth
Immediate Cause (Finel disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease	
Due to (or es e consequence of):	
Sequentielly list conditions, if any, leeding to immediate ceuse. Enter Underlying Cause (Diseese or Injury thet initiated events resulting in death) Last b.	
Due to (or es e consequence of):	
c.	
Due to (or es e consequence of):	
d.	
[ ] UNPENDED [ ] AMENDED	

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	23d. Dete of delivery
1 [ ] Yes 2 [ ] No 9 [ ] Unknown	1 [ ] Live birth 2 [ ] Fetal death 3 [ ] Ectopic pregnancy 4 [ ] Pregnent et time of death 5 [ ] Other *(Specify)* 9 [ ] Unknown	Month Day Yeer

Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

Sleep Apnea, Morbid Obesity.

23e. Did tobecco use contribute to the cause of death?	24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth?
1 [ ] Yes 2 [ ] No 3 [ ] Probebly 4 [✓] Unknown	1 [ ] Yes 2 [✓] No	1 [ ] Yes 2 [ ] No

25. Was case referred to medical exeminer?	26. Place of Death (Check only one)
1 [✓] Yes 2 [ ] No	Hospital: 1 [ ] Inpetient 2 [✓] ER/Outpetient 3 [ ] DOA Other: 4 [ ] Nursing Home 5 [ ] Residance 6 [ ] Other:

27. Manner of Death	28a. Date of Injury (Month, Day, Yeer)	28b. Time of Injury	28c. Injury et Work?	28d. Describe how injury occurred
1 [✓] Natural 2 [ ] Accident 3 [ ] Suicide 4 [ ] Homicide 5 [ ] Pending Investigation 6 [ ] Could not be determined			1 [ ] Yes 2 [ ] No	
	28e. Piece of Injury - At home, farm, street, factory, office building, etc. *(Specify)*			28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

29a. Certifier *(Check only one)*: 1 [ ] **Certifying Physician:** To the best of my knowledge, death occurred et the time, date end place, end due to the ceuse(s) and menner es steted.
2 [✓] **Medicel Exeminer:** On the besis of exemination end/or Investigetion, in my opinion, death occurred et the time, dete end place, end due to the ceuse(s) and manner stated.

29b. Signeture and title of certifier	29c. License number	29d. Dete signed *(Month, Day, Year)*
Jack M. Titus	O.C.M.E.	February 22, 2007 (Re-issued)

30. Name end eddress of person who completed cause of death (Item 23e)
Jack Titus MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

State Registrar

31. Date filed *(Month, Day, Year)*	32. Registrar's Signature
MAR 0 2 2007	

ORIGINAL

DHMH 17 Rev 1/2001
OCME 2006

Baltimore, MD 21215-0036
permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

To Be Completed by Funeral Director

Division of Vital Records, P.O. Box 68760,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit